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In The Supreme Court of the United States

October Term, 1994

TRI-STATE MACHINE, INC.,

Petitioner,

vs.

NATIONWIDE LIFE INSURANCE COMPANY,

Respondent.

Petition for Writ of Certiorari to the United States Court of Appeals for the Fourth Circuit

PETITION FOR WRIT OF CERTIORARI

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12 pp

QUESTIONS PRESENTED FOR REVIEW

1. Where an insurance company fraudulently computes the premiums an employer must pay for employer-sponsored health care coverage, do the employer's state law claims for violation of common and statutory law "relate to" a benefit plan such that they are preempted by ERISA?

2. Are state insurance laws as applied to the claim of an employer against an insurance company arising out of the fraudulent computation of insurance premiums saved from preemption by ERISA's saving clause?

3. Where an employer purchases health insurance for its workers from an insurance company, the effect of which is to transfer risk from the employer to the insurance company, does the insurance create a "self-funded plan" such that the employer's claims against the insurance company cannot be saved from preemption?

4. Does ERISA or federal common law provide a remedy for an employer who has been defrauded in the purchase of health care insurance for its employees?

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OFFICIAL AND UNOFFICIAL REPORTS OF OPINIONS DELIVERED IN THIS CASE

The decision of the United States Court of Appeals for the Fourth Circuit is reported at 33 F.3d 309 (4th Cir. 1994). The decision of the United States District Court for the Northern District of West Virginia is not reported but can be found at 1993 WL 735796 (N.D. W. Va. July 2, 1993).

JURISDICTIONAL GROUNDS

The opinion and judgment of the United States Court of Appeals for the Fourth Circuit sought to be reviewed herein was entered on August 31, 1994. Jurisdiction to review that opinion and judgment by writ of certiorari is conferred on this Court by 28 U.S.C. § 1254 (1988). Petitioner did not seek a rehearing by the Fourth Circuit.

STATUTES INVOLVED IN THE CASE

Section 514 of ERISA reads, in pertinent part, as follows:

(a) **Supersedure; effective date.** Except as provided in subsection (b) of this section, the provisions of this title and title IV shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 4(a) and not exempt under section 4(b). This section shall take effect on January 1, 1975.

(b) **Construction and application.** (1) This section shall not apply with respect to any cause of action which arose, or any act or omission which occurred, before January 1, 1975.

(2)(A) Except as provided in subparagraph (B), nothing in this title shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking or securities.

(B) Neither an employee benefit plan described in section 4(a), which is not exempt under section 4(b) (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

* * *

29 U.S.C. § 1144 (1988).

Section 502(a) of ERISA reads as follows:

(a) **Persons empowered to bring a civil action.** A civil action may be brought—

(1) by a participant or beneficiary—

(A) for the relief provided for in subsection (c) of this section, or

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

(2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 409;

(3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this title or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this title or the terms of the plan;

(4) by the Secretary, or by a participant, or beneficiary for appropriate relief in the case of a violation of 105(c);

(5) except as otherwise provided in subsection (b), by the Secretary (A) to enjoin any act or practice which violates any provision of this title, or (B) to obtain other appropriate equitable relief (i) to redress such violation or (ii) to enforce any provision of this title; or

(6) by the Secretary to collect any civil penalty under subsection (c)(2) or (i) or (1).

29 U.S.C. § 1132(a).

Article 11 of Chapter 33 of the West Virginia Code (entitled "Unfair Trade Practices") states, in pertinent part, as follows:

§ 33-11-1. Declaration of purpose.

The purpose of this article is to regulate trade practices in the business of insurance in accordance with the intent of Congress as expressed in the act of Congress of March ninth, one thousand nine hundred forty-five (Public Law fifteen, seventy-ninth Congress) [the McCarran-Ferguson Act], by defining, or providing for the determination of, all such practices in this State which constitute unfair methods of competition or unfair or deceptive acts or practices and by prohibiting the trade practices so defined or determined. (1957, c. 97; 1974, c. 51.)

W. Va. Code § 33-11-1 (1974)

* * *

§ 33-11-3. Unfair methods of competition and unfair or deceptive acts or practices prohibited.

No person shall engage in this State in any trade practice which is defined in this article as, or determined pursuant to section seven [§ 33-11-7] of this article to be, an

unfair method of competition or an unfair or deceptive act or practice in the business of insurance. (1957, c. 97; 1974, c. 51.)

W. Va. Code § 33-11-3 (1974)

§ 33-11-4. Unfair methods of competition and unfair or deceptive acts or practices defined.

The following are hereby defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:

* * *

(5) False statements and entries. —(a) No person shall knowingly file with any supervisory or other public official, or knowingly make, publish, disseminate, circulate or deliver to any person, or placed before the public, any false material statement of fact as to the financial condition of a person.

(b) No person shall knowingly make any false entry of a material fact in any book, report or statement of any person or knowingly omit to make a true entry of any material fact pertaining to the business of such person in any book, report or statement of such person.

* * *

W. Va. Code § 33-11-4 (1974)

STATEMENT OF THE CASE

Background Facts

Tri-State Machine, Inc. ("Tri-State")[1] contracted with Nationwide Life Insurance Company ("Nationwide") to have Nationwide provide insurance for Tri-State's employees. Tri-State purchased a combination of health, life, prescription drug, dental and total disability insurance (the "Policy") which was used to fund the employee benefit plan sponsored by Tri-State (the "Tri-State benefit plan"). Tri-State's premium payments were to be calculated according to a Cash Priority Plan Funding Agreement (the "Funding Agreement").

Nationwide and its agents administered the Tri-State benefit plan and paid claims submitted by Tri-State's employees as contractually bound to do under the Policy. The Policy required Nationwide to provide insurance to each of Tri-State's employees and their families, and to administer the claims. For example, Nationwide and its agents would determine whether an employee's medical claim was covered and, if so, the claim was paid by Nationwide. Tri-State did not pay claims or have any role in the claims adjudication process. Tri-State had no role in the administration of the Tri-State benefit plan. In short, Tri-State had no discretion relative to the plan and, as such, was not a plan fiduciary within the meaning of ERISA.

Like any employer that purchases insurance for its employees, Tri-State's insurance premiums were based upon a number of factors: volume of claims, nature of claims, volume of life insurance, number of lives insured and, of course, the amount of those claims. Under the Funding Agreement, Nationwide reported claims information to Tri-State and collected premiums

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[1]Tri-State has no parent or subsidiary corporations.

based on that information. The premiums were the sum of various factors: an amount to cover Nationwide's cost of administering the plan; another amount equal to the aggregate of all claims under $25,000 per year/per employee; plus an additional amount to cover the risk assumed by Nationwide to absorb any claims per individual that exceeded $25,000 in any given policy year and the risk assumed by Nationwide of paying any and all claims that exceeded the annual cap.[2] Thus, Nationwide's exposure depended upon the amount and timing of the payment of claims to Tri-State's employees.

As far as Tri-State could determine, Nationwide properly determined coverage issues over the course of the years that the insurance was in place. Likewise, where Nationwide determined that the Policy provided coverage, it timely paid claims on behalf of Tri-State's employees to their health care providers.

However, when it came time for Nationwide to report claims information to Tri-State and to calculate Tri-State's insurance premium, Nationwide acted dishonestly in an attempt, successful to date, to save itself money. For purposes of calculating Tri-State's obligation to pay premiums, Nationwide manipulated the posting of dates on which Nationwide paid claims so as to increase Tri-State's insurance premium. Nationwide fraudulently reported to Tri-State that claims were paid later than when actually paid, so as to "spread out" the claims of employees. Spreading out the time periods in which claims were paid by Nationwide created the appearance, falsely, that certain Tri-State employees had claims less than or equal to $25,000 per year, when in fact their claims exceeded $25,000. In addition, in direct violation of the terms of the Funding Agreement, Nationwide

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[2]The Funding Agreement contained a cap on the premiums that Tri-State was required pay in any given year. For example, the maximum amount payable during the first year of the Funding Agreement was approximately $130,000.

grouped medical, dental, prescription and major medical claims into one monthly amount which was applied towards the "monthly policyholder liability limit amount," so as to increase Tri-State's insurance premium.

Nationwide also reported claims as having been paid in the year subsequent to when actually paid to avoid the annual cap on Tri-State's maximum premium liability. In other words, Nationwide ceased posting claims to Tri-State's account before the end of any given plan year. When a new year began under the Funding Agreement, wherein Tri-State would be fully responsible for the maximum premium liability, Nationwide resumed posting claims to Tri-State's account. Claims which had been paid months before were suddenly posted to Tri-State's account and were applied against Tri-State's new premium limit. This purposeful manipulation of information caused Tri-State's premiums to be much higher than they otherwise would have been. The manipulation of data fraudulently allowed Nationwide to recoup, on a dollar-for-dollar basis, more than it was entitled to under the terms of the Funding Agreement.

Proceedings Below

After discovering Nationwide's fraud, Tri-State sued Nationwide in West Virginia state court. The complaint alleged various theories of recovery such as breach of contract, breach of implied covenant of good faith and fair dealing, statutory "bad faith," and violation of West Virginia insurance laws. Nationwide removed the case to the United States District Court for the Northern District of West Virginia alleging that Tri-State's claims were governed and preempted by ERISA. The District Court ruled that diversity jurisdiction existed pursuant to 28 U.S.C. § 1332(a) (1988).

Initially, Tri-State moved for partial summary judgment seeking a determination from the District Court that ERISA did

not preempt Tri-State's state law causes of action because the fraudulent conduct involved the sale of insurance and did not "relate to" the administration of an ERISA plan. Although it did not formally dismiss Tri-State, the District Court denied the motion, ruling that all of Tri-State's claims based on West Virginia law were preempted by ERISA.[3] The District Court certified the preemption issue to the Fourth Circuit; however, the appellate court declined to hear the issue at that time.[4]

Tri-State later sought entry of a final order under Rule 54(b) in an attempt to have the District Court acknowledge that it had effectively dismissed Tri-State's state law claims from the case. The entry of a final judgment under Rule 54(b) would have allowed Tri-State to appeal the ERISA preemption issue.

On July 2, 1993, the District Court issued an order in which it refused Tri-State's request for a Rule 54(b) final judgment and refused to alter its finding that Tri-State's state law causes of action were preempted by ERISA.[5] The District Court further refused to find that the facts, as alleged, formed the basis for federal common law or ERISA claims and, instead, issued summary judgment *sua sponte* for Nationwide. This final order was appealed to and heard by the Fourth Circuit pursuant to 28 U.S.C. § 1291 (1982).

The Fourth Circuit affirmed by a 2-1 majority.[6] The Fourth Circuit's analysis was similar to that of the District Court: Tri-State's claims "related to" an ERISA plan; the insurance

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[3]The District Court's opinion and order denying Tri-State's motion for summary judgment is found at pages 1a - 4a of the appendix to the petition.

[4]The Fourth Circuit's order denying permission to appeal is found at page 7a of the appendix.

[5]The District Court's opinion and order granting summary judgment against Tri-State is found at pages 8a - 14a of the appendix.

[6]The Fourth Circuit's opinion and order is found at pages 15a - 34a of the appendix.

laws asserted to be applicable were not "saved" from preemption; therefore, all of Tri-State's claims arising under West Virginia common or statutory law were preempted. As to Tri-State's argument that claims arising under West Virginia's Insurance Code were "saved" from preemption by ERISA's saving clause, both courts rotely cited precedent standing for the proposition that self-funded plans are exempt from state insurance laws by virtue of the "deemer" clause. ERISA Section 514(b)(2)(B).

These analyses failed to recognize that Nationwide is not an employee benefit plan but, rather, an insurance company. The lower courts mistakenly reasoned that since the Policy had some stop-loss insurance features, the Policy was actually a self-funded plan which could not be deemed to be an insurance company or an insurer. The Fourth Circuit additionally held that the insurance provision of the West Virginia Code which Tri-State sued under was not a "law regulating insurance" within the meaning of ERISA's saving clause.

Tri-State was defrauded in the purchase of insurance for its employee benefit plan. Various state law causes of action were brought against Nationwide to remedy the wrong, but each cause of action was held to be preempted, even though the face of the Policy clearly states "SUBJECT TO THE LAWS OF THE STATE IN WHICH IT IS DELIVERED." Thus far Tri-State has been left without either state or federal remedies against Nationwide to redress an obvious insurance fraud.

ARGUMENT

I. IMPORTANCE OF DECISION

A. Importance of Encouraging the Development and Continuation of Employer-Sponsored Benefit Plans and Preventing Insurance Company Fraud.

It is very important for the Court to hear this appeal because the matters at issue affect the societal and legislatively-expressed interest in encouraging employers to sponsor health care benefits for their employees.

This case is also immensely important because it affects the enforceability of every state's Unfair Trade Practices Act against insurance companies in the sale of insurance products. Over 27 states have enacted an unfair trade practices act based on the model act proposed by the National Association of Insurance Commissioners.[7] If this case is not heard, Nationwide and other insurers can be expected to continue to engage in their fraudulent business practices under the protection of the ERISA preemption shield.

There is every reason to believe that the manipulation of claims to generate increased premiums is a widespread practice within the multi-billion dollar business[8] of providing insurance products to fund ERISA welfare benefit plans (*i.e.*, employer-sponsored health care). Yet, to date, this Court has not had occasion to address the effect of ERISA on regulating the sale of insurance products by insurance companies to employers within the context of employer-sponsored benefit plans.

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[7]Douglas G. Houser, *Unfair Claims Settlement Practices Act - How the Courts Have Interpreted the Act,* 15 The Forum 336 (1979).

[8]According to the Statistical Abstract of the United States 1994, Table No. 155, businesses paid $152.7 billion in private health insurance premiums in 1991.

The end result of decisions like the one being appealed from - decisions which broadly interpret the scope of ERISA preemption, yet narrowly construe the saving clause - is the opposite of what Congress intended.

If an individual or a corporation bought insurance in West Virginia and was victimized by the type of fraud Tri-State alleges against Nationwide, those persons would have claims under West Virginia's Unfair Trade Practices Act for compensatory and punitive damages. However, under the decisions issued by the District Court and the Fourth Circuit in this case, an employer who funds a benefit plan by purchasing an insurance package from an insurance company is deprived of remedies against an insurance company - remedies that any other purchaser of insurance would possess. That result is wrong and will have strong negative repercussions throughout the United States because it allows insurance companies to raise the shield of ERISA preemption and protect themselves not only against the employee beneficiaries of a welfare plan, but against employers who sponsor plans. Tri-State's counterparts within the small business community will surely be apprised of Tri-State's inability to obtain redress against Nationwide's fraud and will be unquestionably opposed to running the same risk.

The model unfair practices act is designed to force insurance companies to conform to certain standards of conduct. Likewise, states throughout the nation have developed other statutory and common law remedies which vigorously protect purchasers of insurance against insurance fraud. Under the rationale of cases extending ERISA preemption to insurance fraud, these state law protections are nonexistent whenever an insurance product is purchased to fund an employee benefit plan. Yet, the sale of and payment for insurance is surely not an area Congress sought to preempt when ERISA was enacted. Indeed, Congress

specifically carved out of preemption, through the saving clause, laws regulating the business of insurance.

Employers should be given every benefit and should be extended the protection of state insurance laws where they purchase insurance related to an ERISA employee benefit plan. The purposes of ERISA are furthered if ERISA is interpreted to limit the remedies of a participant against his employer, thereby creating an incentive for the employer to provide health benefits to its employees. However, if state-provided remedies are stripped from an employer purchasing insurance for a plan, then the Court has placed a serious burden on an employer providing health benefits for its employees.

It is Tri-State's contention that Congress intended to restrict the displacement of state law to those areas with which ERISA is directly concerned—*i.e.*, primarily the operation and administration of plans, and to leave state law in place to the extent it does not affect those core concerns.

The effect of the lower courts' decisions in this case is that insurance companies have no strong disincentive to manipulate premium calculations to defraud employers in connection with employer-sponsored health care. Nationwide and other companies in the insurance business are currently enjoying this windfall and, as such, have no incentive to ferret out and alter the fraudulent practices of their employees. This is especially significant when one considers that insurance companies process billions of dollars of claims per month from which employer-sponsored health care premiums are calculated.

B. Strong Concerns of Federalism are at Stake.

The effect of the Fourth Circuit's decision and other decisions like it is to take power from the States and give it to the federal government.

It is well established that Congress can supplant state statutes and common law with federal law, especially where an issue of such importance as employee benefits is at stake. ERISA's preemption provisions are deliberately expansive, and designed to establish pension plan regulation as exclusively a federal concern. *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 138 (1990); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 45-46 (1987).

However, it is equally clear that with the passage of ERISA, Congress intended to retain in the States the ability to regulate insurance companies and insurance practices. "We also must presume that Congress did not intend to pre-empt areas of traditional regulation." *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 740 (1985).

States have a keen interest in controlling and policing the actions of insurance companies, and each state goes about it differently. States like West Virginia have established an Insurance Commission and have enacted detailed laws and regulations regarding all aspects of insurance. West Virginia and other states also devote substantial time, money and effort to protect their citizens in their dealings with insurance companies. Indeed, in virtually every state, employers comprise a huge segment of those purchasing insurance.[9]

For courts such as the Fourth Circuit to interpret ERISA so as to displace the bulk of state insurance laws as they might be invoked by sponsors of employee benefit plans, is to rob the

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[9]Employers in West Virginia, for example, pay over $20 million per year in accident and health insurance premiums. *1992 Annual Report of the West Virginia Insurance Commissioner.* Insurance companies pay an insurance premium tax to the State of West Virginia when insurance is purchased by West Virginia resident companies. The purpose of the premium tax is to help defray the cost of the insurance commissioner, staff and regulating agencies to "regulate insurance."

States of a very large and important area of traditional state concern. Such a broad reading of ERISA also unnecessarily and improperly empowers insurance companies.

This case is not about paying claims to any care provider; nor is this case about providing benefits to or for any participant or beneficiary. This case is about one company (Nationwide) breaching its contract with another company (Tri-State). It is about the lower courts ignoring a contract which, as presented and sold, clearly stated "Subject to the Laws of the State in Which it is Delivered." By stripping state law remedies from an insurance purchaser, the lower courts have also taken from the States their rights to protect employers or other purchasers of insurance. This case is merely a billing dispute over the billing procedures of one company to another company.

Insurance companies are not placed under an extra burden by being required to comply with state laws relating to the sale of insurance products for employee benefit plans. To the contrary, if the same type of policies as in question here are sold outside the arena of employee benefits, insurance companies must comply with state law (like West Virginia's Unfair Trade Practices Act). Similarly, insurance companies are required to comply with the same state insurance laws in the sale of every other type of insurance product. There is no good reason for relieving insurance companies of such burden for the sale of employee benefit plan policies.

Because federal courts throughout the country are tending to expansively construe the scope of ERISA preemption and narrowly construe the saving clause, the balance of power between the States and the federal government is at stake. This is a concern that has a very real effect on all States, and on all employers and employees who choose to do business in any particular state. It is an issue that strikes at the core of our federalism. As such, this case presents questions of important public concern.

II. THE CIRCUITS ARE SPLIT AS TO THE TEST TO BE USED IN DETERMINING THE SCOPE OF THE "RELATE TO" CLAUSE, THE "SAVING CLAUSE" AND THE "DEEMER CLAUSE" OF SECTION 514 OF ERISA

One of the primary goals of Congress in enacting ERISA was to encourage the creation and continuation of employer-sponsored employee benefit plans by defining, yet limiting, the universe of claims and remedies that may be sought by plan beneficiaries. Section 514 of ERISA, 29 U.S.C. § 1144, the broad preemption provision, minimizes the burden upon plans and their sponsors of complying with complex and conflicting state regulations. State laws that "relate to any employee benefit plan" are preempted. 29 U.S.C. § 1144(a).

At the same time Congress sought to preempt this area of federal concern, Congress also expressly permitted the States to continue to regulate insurance companies via Section 514(b)(2)(A) of ERISA (the "saving clause"), 29 U.S.C. § 1144(b)(2)(A) (" . . . nothing in this title shall be construed to exempt or relieve any person from any law of any State which regulates insurance . . . "). The "deemer clause" of ERISA then states that no employee benefit plan "shall be deemed to be an insurance company or other insurer." 29 U.S.C. § 1144(b)(2)(B) (1988). Congress feared that if this provision were not added, an employee benefit plan might, itself, be forced to follow a variety of burdensome state insurance laws and regulations.

The foregoing three clauses in Section 514 of ERISA affect the scope of ERISA preemption. A separate test has been developed for each clause, and the circuits are split in how they apply the tests for each clause.

A. Judicial Construction of the "Relate To" Clause.

The circuits are split as to the proper construction of the "relate to" clause. The central question giving rise to the split is

whether ERISA preempts claims that relate in some manner to ERISA plans, but for which ERISA provides no express remedy.

Some circuits have held that the "relate to" clause of ERISA Section 514(a) is to be given a broad construction and, consequently, that courts must create federal common law rights and remedies to deal with such preempted claims. Other circuits have come to a contrary conclusion, reasoning that although ERISA broadly preempts all areas with which it is concerned, the "relate to" clause should be narrowly construed when areas of traditional state concern are at stake for which ERISA provides no remedies.

In the case in question, the Fourth Circuit held Tri-State's state law claims to be preempted, even though ERISA provides no remedy for the claims alleged, and even though Tri-State, as a non-fiduciary plan sponsor, apparently is not authorized to sue under ERISA's civil enforcement provisions.

In addition to the Fourth Circuit's decision below, a case decided by the Eleventh Circuit provides a good example of the view that ERISA preempts all claims, even those not implicating the rights of plan participants and beneficiaries. In *First Nat'l Life Ins. Co. v. Sunshine-Jr. Food Stores, Inc.*, 960 F.2d 1546 (11th Cir. 1992), *cert. denied*, ___U.S. ___, 113 S.Ct. 1045 (1993), an insurance company brought claims against an employer for the employer's failure to adhere to certain conditions under which a group insurance policy was issued, such as an alleged failure to maintain 75% employee participation in the plan. The insurance served as an employer-sponsored benefit plan. Although ERISA obviously has no express provisions or remedies addressing such a dispute, the Eleventh Circuit found that, because the claims "related to" a plan, all state laws concerning such a dispute were preempted. Consequently, any remedy must be under ERISA or federal common law to fill the "gaps" of ERISA.

The Fourth and Eleventh Circuits are not alone in being unable to risk the temptation of expanding the scope of federal law to areas of traditional state law concern. *See, e.g., Consolidated Beef Indus. v. New York Life Ins. Co.*, 949 F.2d 960, 964 (8th Cir. 1991), *cert. denied*, ___ U.S. ___, 112 S.Ct. 1670 (1992) (employer has no remedy because its claim of misrepresentation in the sale of an insurance program related to the plan and was, therefore, preempted); *Farlow v. Union Cent. Life Ins. Co.*, 874 F.2d 791, 794 (11th Cir. 1989), (claims arising out of misconduct in the sale of a plan are preempted, since "a state law claim relates to a plan for preemption purposes as long as it is not 'wholly remote in content' "); *Washington Nat'l Ins. Co. v. Hendricks*, 855 F. Supp. 1542 (W.D. Wis. 1994) (where an insurer sued an employer for unpaid premiums and the employer counterclaimed for what it alleged to be the improper termination of an insurance policy, held that these actions related to an ERISA plan and that courts were empowered to create causes of action for breach of contract and similar state law theories under ERISA).

Other circuits, in contradiction to the Fourth, Eighth and Eleventh Circuits, have limited the preemptive effect of the "relate to" provision to benefits administration and processing issues. These courts hold that ERISA concerns itself only with the rights of fiduciaries and beneficiaries in the administration of a plan, recognizing that Congress did not intend to preempt the application of state laws to what are essentially commercial disputes.

For example, in *Airparts Co., Inc. v. Custom Benefit Services of Austin, Inc.*, 28 F.3d 1062 (10th Cir. 1994), an employer who sponsored a plan brought claims of negligence and common law fraud against a consultant to the employee benefit plan administrators. The employer alleged that the consultant failed to

diversity of citizenship and federal question, arguing that Tri-State's complaint is completely preempted by 29 U.S.C. § 1001 et seq., the Employee Retirement Income Security Act of 1974 ("ERISA"). The Court subsequently denied Tri-State's motion for remand finding that diversity jurisdiction existed, but declined to rule on the ERISA preemption issue.

Tri-State now moves for partial summary judgment on the ERISA preemption issue. Nationwide claims that the preemption issue cannot be determined by summary judgment, and moves to have the motion stricken. In its answer, Nationwide asserts as its first affirmative defense that Tri-State's complaint is preempted by ERISA. Tri-State now seeks a ruling by the Court that, as a matter of law, its claims are not preempted by ERISA. Summary judgment is an appropriate vehicle for such a ruling. Therefore, Nationwide's motion to strike is DENIED.

Proceeding to the merits of Tri-State's motion, the complaint clearly relates to an employee welfare benefit plan as defined in ERISA § 1002(1)(A). Tri-State argues that Nationwide lacks standing to assert its preemption defense. Said argument is without merit. There is no requirement that a defendant have standing to be sued.

Apparently, Tri-State seeks to circumvent preemption by arguing that ERISA is designed to protect employees and beneficiaries; that it is not applicable to contracts between employers and insurance companies. However, ERISA provides broad coverage, including actions such as the one before the Court. Both parties are definitely plan fiduciaries. As such, § 1132(a)(2) permits Tri-State to maintain a § 1109 action against Nationwide.[1]

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[1]Even if Tri-State was not a fiduciary, it would probably be able to maintain a suit against Nationwide under ERISA federal common law. *See Plumbers & Steamfitters Local Union No. 152 etc. v. Bland*, 745 F. Supp. 1172 (N.D.W.Va. 1990).

Therefore, under § 1144(a), ERISA preempts all of Tri-State's claims based upon West Virginia laws relating to the health insurance plan upon which its complaint is based. *See FMC Corp. v. Holliday,* 111 S. Ct. 403 (1990); *Metropolitan Life Ins. Co. v. Massachusetts,* 471 U.S. 724 (1985); *Thompson v. Talquin Bldg. Products Co.,* 928 F.2d 649 (4th Cir. 1991); *Powell v. Chesapeake & Potomac Tel. Co.,* 780 F.2d 419 (4th Cir. 1985).

Having so found general preemption, Tri-State argues that its claims based upon the West Virginia Trade Practices act are saved from preemption under § 1144(b)(2). This savings clause, however, is limited by § 1144(b)(2)(B), also known as the "deemer" clause. The deemer clause excludes self-funded benefit plans from the savings clause. *FMC Corp. v. Holliday, supra.*

The plan involved herein is a self-funded plan. Therefore, under the deemer clause, the plan cannot be regulated by the West Virginia Trade Practices Act. The fact that Nationwide provides stop-loss coverage does not change this outcome. *Thompson v. Talquin Bldg. Products Co., supra.* Also, the outcome is not changed by the fact that Nationwide provides administrative claims processing functions for Tri-State. *Powell v. Chesapeake & Potomac Tel. Co., supra.*

Accordingly, the Court is of the opinion that plaintiff's motion for partial summary judgment should be DENIED.

It is so ORDERED.

The Clerk is directed to transmit certified copies of this Memorandum Opinion and Order to counsel of record herein.

ENTER:

/s/ WILLIAM M. KIDD

WILLIAM M. KIDD
UNITED STATES DISTRICT JUDGE

Filed September 23, 1991

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF WEST VIRGINIA

ORDER FILED
February 27, 1992

TRI-STATE MACHINE, INC.,
Plaintiff,

Vs. CIVIL ACTION NO. 90-0027-W(K)

NATIONWIDE LIFE INSURANCE COMPANY,

Defendant.

ORDER

Currently pending is the plaintiff's motion for reconsideration or, in the alternative, for certification to the Fourth Circuit Court of Appeals, pursuant to 28 U.S.C. § 1292(b). Defendant has filed its opposition to both motions.

In regard to the plaintiff's motion for reconsideration of the Court's Memorandum Opinion and Order, entered September 23, 1991, the Court finds that the plaintiff has cited no grounds warranting reconsideration. The plaintiff's action is completely preempted by 29 U.S.C. § 1001 et seq., the Employee Retirement Income Security Act of 1974 ("ERISA"). Therefore, plaintiff's motion for reconsideration is DENIED.

In regard to plaintiff's motion for the Court to certify an appeal of its Memorandum Opinion and Order to the Fourth Circuit pursuant to 28 U.S.C. § 1292(b), the Court is of the opinion that its ruling does involve a controlling question of law as to which there is substantial ground for difference of opinion and that an immediate appeal may materially advance the ultimate termination of this action. The Court agrees with the defendant that certifications are the exception, not the rule. However, there

is no doubt that the Court's ruling on the question of law, in effect, eliminates the plaintiff's case. Furthermore, as aptly cited by the plaintiff, the ERISA preemption question "was caught up in the 'ERISA quicksand.' " The Court believes that the law is not as clear as the defendant asserts and that there is substantial ground for difference of opinion.

Accordingly, the Court is of the opinion that the plaintiff's motion to certify an appeal of the Court's Memorandum Opinion and Order to the Fourth Circuit is hereby GRANTED. This finding is made pursuant to 28 U.S.C. § 1292(b) which grants appellate jurisdiction upon the Fourth Circuit Court of Appeals which may, in its discretion, permit an immediate appeal to be taken if, within ten (10) days of entry of this Order, an application is made. Furthermore, the Court hereby STAYS all further proceedings before the Court.

It is so ORDERED.

The Clerk is directed to transmit certified copies of this Order to counsel of record herein.

ENTER:

/s/ WILLIAM M. KIDD

WILLIAM M. KIDD
UNITED STATES DISTRICT JUDGE

UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

FILED
March 26, 1992

TRI-STATE MACHINE, INCORPORATED,
Petitioner

v. No. 92-8022

NATIONWIDE LIFE INSURANCE COMPANY, an Ohio Corporation CA-90-00-27-W(K)

Respondent

ORDER

Petitioner has filed a petition for permission to appeal an interlocutory order pursuant to 28 U.S.C. 1292(b).

The Court denies the petition for permission to appeal.

Entered at the direction of Judge Niemeyer, with the concurrence of Judge Hall and Judge Phillips.

For the Court,

/s/ JOHN M. GREACEN

Clerk

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF WEST VIRGINIA

ORDER FILED
JULY 2, 1993

TRI-STATE MACHINE, INC.,
Plaintiff,

Vs. CIVIL ACTION NO. 90-0027-W(K)

NATIONWIDE LIFE INSURANCE COMPANY,

Defendant.

MEMORANDUM OPINION AND ORDER

Once again, the plaintiff Tri-State Machine, Inc. ("Tri-State") petitions the Court to reverse itself and provide a favorable ruling that Tri-State's complaint, which asserts only state causes of actions against defendant Nationwide Life Insurance Company ("Nationwide"), is not preempted by § 514 of the Employee Retirement Income Security Act of 1974 ("ERISA") as set forth at 29 U.S.C. § 1144. In pursuit of its goal, Tri-State has filed a "Conditional Motion for Entry of Final Judgment under Rule 54(b) or, Alternatively, Motion for Summary Judgment and Request for Entry of Final Judgment."[1] Nationwide filed its opposition motion to which Tri-State replied. In addition, Nationwide filed a motion for Rule 11 sanctions which is opposed by Tri-State.

To put this matter in perspective, a brief review of the procedural history is in order. This action was originally filed in the Circuit Court of Ohio County, West Virginia, on February 28,

[1]On the same date, Tri-State also filed a motion for leave to file an amended complaint, a motion to compel, and a motion for oral argument. Said motions have also been fully briefed.

1990. On March 29, 1990, Nationwide removed it, basing jurisdiction on ERISA preemption as well as diversity of citizenship. On April 24, 1990, Tri-State filed its motion for remand, which included a twenty page brief arguing that there was no ERISA preemption, and that diversity was lacking due to the direct action exception found at 28 U.S.C. § 1332(C)(1). Finding the direct action exception inapplicable and that diversity jurisdiction existed, the Court denied the remand motion. The Court did not rule on the preemption issue.

On April 24, 1991, Tri-State filed its motion for partial summary judgment, with attached memorandum, seeking a ruling that its complaint is not preempted by ERISA. On May 17, 1991, Nationwide filed its opposition brief, asserting that Tri-State's entire complaint is preempted by ERISA. Tri-State filed no reply brief.[2] By Memorandum Opinion and Order entered on September 23, 1991, the Court denied Tri-State's motion, holding that all of its state law claims were preempted by ERISA.[3]

On November 29, 1991, Tri-State filed its motion for reconsideration of the Court's denial of its partial summary judgment motion. Alternatively, Tri-State moved for certification pursuant to 28 U.S.C. § 1292(b), should the Court not reconsider its prior ruling. On December 16, 1991, Nationwide filed its opposition to both motions. Again, Tri-State filed no reply brief. By Order entered February 21, 1992, the Court denied Tri-State's motion for reconsideration, but granted its motion for certification. On

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[2]Tri-State complains about Nationwide's alleged misrepresentations of facts and misleading of the Court in its opposition brief regarding the funding of the insurance policy. If this in fact was the case, a reply brief was the proper means to bring it to the Court's attentions.

[3]Tri-State takes issue with the Court's ruling in regard to the "savings" clause and "deemer" clause, found at 29 U.S.C. § 1144(b)(2), claiming that "neither Plaintiff nor Defendant briefed that issue." In its motion for partial summary judgment, Tri-State specifically alleged as its second ground that "29 U.S.C. § 1144(b)(2) exempts the plaintiff's claim from ERISA."

March 26, 1992, the Fourth Circuit Court of Appeals denied Tri-State's petition for permission to appeal.

On April 7, 1992, Tri-State filed its motion to vacate and reenter order of certification, asserting that the Fourth Circuit denied the petition because it was not timely filed. On April 23, 1992, Nationwide filed its opposition brief. Tri-State's reply brief was filed on May 7, 1992. By Order entered June 16, 1992, the Court denied Tri-State's motion, finding that the Fourth Circuit's denial was most likely upon the merits since untimeliness could easily have been remedied if the Fourth Circuit had so desired. The Court also ordered Tri-State to indicate whether it intended to pursue an ERISA claim. By notice filed July 9, 1992, Tri-State informed the Court that it intended to pursue this action under ERISA. However, to date, there has been no effort by Tri-State to amend its complaint to state a cause of action under ERISA.

Instead, Tri-State has filed the motion currently before the Court, as well as a motion for leave to amend two paragraphs of its complaint, with the specific design to avoid ERISA preemption and proceed on the state law claims asserted in its complaint.[4] Specifically, Tri-State asserts that the Court erred by finding the "deemer" clause[5] applicable and that Tri-State was a fiduciary under ERISA. However, neither of these contentions is material to a finding of complete preemption under ERISA.

The Rule 54(b) motion merits little discussion. The Court has not dismissed any claims asserted by Tri-State. The Court

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[4]Specifically, Tri-State seeks to amend its complaint to allege that the group insurance policy was not self-funded, in furtherance of its attempt to avoid preemption. Tri-State makes no effort to also add an ERISA claim to its complaint.

[5]The "deemer" clause is found at § 406(b)(2)(B) [sic] of ERISA, 29 U.S.C. § 1144(b)(2)(B). The "savings" clause is found at § 406(b)(2)(A) [sic] of ERISA, 29 U.S.C. § 1144(b)(2)(A).

denied Tri-State's partial summary judgment motion. Therefore, there is nothing to enter partial judgment upon. The proper mechanism for review of this decision was certification, which the Fourth Circuit denied. Accordingly, Tri-State's Rule 54(b) motion is DENIED.

Preemption under ERISA is "conspicuous for its breadth." *FMC Corp. v. Holliday*, 498 U.S. 52, 111 S. Ct. 403, 407 (1990). If the state cause of action "relates to" an employee welfare benefit plan, it is preempted. *See Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 111 S. Ct. 478 (1990). Tri-State concedes: "It is clear that the employee benefit plan sponsored by Plaintiff is an 'employee welfare benefit plan' for purposes of ERISA." Furthermore, as stated in its memorandum of law in support of motion to remand, filed on April 24, 1990, Tri-State characterized its complaint as follows:

> . . . Specifically, it is alleged that defendant breached its duties to administer the benefits program and failed to determine what claims should be paid or what claims should not be paid. It is alleged that defendant failed to timely process claims with the intent of imposing liability on plaintiff under the stop-loss provisions of the plan, and that defendant deliberately mismanaged the contract. It is alleged that defendant breached its fiduciary duty to plaintiff and that defendant breached the implied covenants of good faith and fair dealing. It is also alleged that defendant misrepresented pertinent facts of the insurance policy and committed the common law and statutory offense of "insurance bad faith." Further, it is alleged that defendant's actions violated the applicable law of the State of West Virginia, including the rules and regulations of the Insurance Commissioner of the State of West Virginia and, more specifically, Series XV-V-1981, Unfair Trade Practices, relating to deceptive and unfair trade practices.
>
> . . . .

> However, it is plaintiff's contention that its claim is based entirely and solely upon state law and does not invoke ERISA original jurisdiction.

More than three years later, Tri-State's position has not changed. In its reply brief, filed on May 20, 1993, Tri-State states: "In our case, Plaintiff, as an insurance purchaser, is seeking damages for fraudulent conduct under an insurance contract." It is inconceivable to the Court how Tri-State can continue to argue that its complaint for improper plan administration does not relate to the employee welfare benefit plan alleged to have been improperly administered by Nationwide. *See Diduck v. Kaszycki & Sons Contractors, Inc.*, 974 F.2d 270, 288 (2nd Cir. 1992) ("The fraud alleged 'relates to' an ERISA-regulated employee benefit plan because it concerns the conduct of a fiduciary and third parties in relation to the plan."); *Consolidated Beef Industries, Inc. v. New York Life Ins. Co.*, 949 F.2d 960, 963 (8th Cir. 1991) ("Given ERISA's broad pre-emption provision, state law claims for improper plan administration are pre-empted."); *Howard v. Parisian, Inc.*, 807 F.2d 1560, 1564 (11th Cir. 1897) [sic] ("However, if a state law claim arises out of the administration of benefits under a plan, the claim is preempted").

The fact that Tri-State claims that it is not a fiduciary is immaterial to preemption. Although the Court has no doubt that Tri-State is a fiduciary, and has so found, if it were not, it would still be able to pursue a federal common law ERISA remedy under *Provident Life & Acci. Ins. Co. v. Waller*, 906 F.2d 985 (4th Cir. 1990). *See Whitworth Bros. Storage Co. v. Central States, Southeast & Southwest Areas Pension Fund*, 794 F.2d 221 (6th Cir. 1986). Accordingly, as a matter of law, the Court holds that all of the claims asserted in Tri-State's complaint relate to the employees welfare benefit plan.

Tri-State's final argument is that the "deemer" clause is inapplicable and that the "savings" clause would not exempt its

claims from ERISA preemption. Even if the Court were to reverse its finding that Tri-State was self-funding, and hold that the "deemer" clause was inapplicable, all of Tri-State's claims would still be preempted. The "savings" clause only applies to state laws that "regulate insurance." Whether a state law regulates insurance is a question of federal law. Federal courts have consistently held that "bad faith" claims as well as "deceptive and unfair trade practices" claims, whether based upon statute or common law, are not laws that regulate insurance.

In order for a state law to regulate insurance it must have the effect of "spreading and underwriting of a policyholders' [sic] risk." *Powell v. Chesapeake & Potomac Telephone Co.*, 780 F.2d 419, 423 (1985). The state laws asserted by Tri-State against Nationwide do not do so. The state laws asserted do not regulate the type of insurance contract which could be issued, nor mandate any benefits which must be included in the insurance contract. Simply put, the state laws do not regulate insurance within the meaning of the "savings" clause. *See Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985); *Stuart Circle Hospital Corp. v. Aetna Health Management*, ___ F.2d ___ (4th Cir. June 2, 1993); *Hogan v. Kraft Foods*, 969 F.2d 142, 145 (5th Cir. 1992); *International Resources, Inc. v. New York Life Ins. Co.*, 950 F.2d 294 (6th Cir. 1991). Accordingly, the "savings" clause is inapplicable.

Therefore, it is still the opinion of the Court that § 406 [sic] of ERISA, 29 U.S.C. § 1144(a), preempts all of Tri-State's claims asserted in its complaint. In that this issue has been repeatedly and exhaustively briefed, in that Tri-State has fully defended and has presented all material pertinent to its claim, and since Tri-State has failed to seek leave to amend its complaint to assert an ERISA claim, the Court hereby GRANTS

summary judgment *sua sponte* for Nationwide, and hereby DISMISSES this action.[6] *See Pension Ben. Guaranty Corporation v. Mize Co.*, 987 F.2d 1059, 1061 (4th Cir. 1993); *Portsmouth Square, Inc. v. Shareholders Protective Committee*, 770 F.2d 866, 869 (9th Cir. 1985) ("For example, *sua sponte* summary judgment is appropriate where one party moves for summary judgment and, after hearing, it appears from all the evidence presented that there is no genuine issue of material fact and the *non-moving* party is entitled to judgment as a matter of law."). In light of the Court's ruling herein, all remaining motions are DENIED.

It is so ORDERED.

Judgment shall be entered accordingly, and this action shall be dismissed and removed from the docket of the Court.

The Clerk is directed to transmit certified copies of this Memorandum Opinion and Order to counsel of record herein.

ENTER: July 2, 1993

/s/ WILLIAM M. KIDD

WILLIAM M. KIDD
UNITED STATES DISTRICT JUDGE

[6]In essence, by granting summary judgment against Tri-State, the Court has made possible the appeal Tri-State sought in its Rule 54(b) motion.

PUBLISHED

UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

Tri-State Machine, Incorporated,
Plaintiff-Appellant,

v. No. 93-1971

Nationwide Life Insurance Company,
Defendant-Appellee.

Appeal from the United States District Court
for the Northern District of West Virginia, at Elkins.
William M. Kidd, Senior District Judge.
(CA-90-27-W-K)

Argued: March 9, 1994

Decided: August 31, 1994

Before NIEMEYER and LUTTIG, Circuit Judges,
and PHILLIPS, Senior Circuit Judge.

Affirmed by published opinion. Judge Niemeyer wrote the opinion, in which Senior Judge Phillips joined. Judge Luttig wrote a separate dissenting opinion.

COUNSEL

ARGUED: David B. Fawcett, III, BUCHANAN INGERSOLL PROFESSIONAL CORPORATION, Pittsburgh, Pennsylvania, for Appellant. Gregory Darwin Port, CHORPENNING, GOOD & MANCUSO CO., L.P.A., Columbus, Ohio, for Appellee. **ON BRIEF:** James W. Forsyth, BUCHANAN INGERSOLL PROFESSIONAL CORPORATION, Pittsburgh, Pennsylvania; Ray A. Byrd, SCHRADER, RECHT, BYRD, BYRUM & COMPANION, Wheeling, West Virginia, for Appellant. Philip F. Brown, CHORPENNING, GOOD & MANCUSO CO., L.P.A., Columbus, Ohio, for Appellee.

give timely advice, improperly calculated pension benefits, proposed and drafted a useless plan amendment, and deliberately concealed the cost of the amendment and its eventual uselessness. The Tenth Circuit recognized that claims obviously having some relationship to an ERISA plan did not "relate to an ERISA plan" within the meaning of ERISA's preemption provision:

> [It] is clear that the state law claims here do not relate to an ERISA plan. The state laws involved do not regulate the type of benefits or terms of the plan; they do not create reporting, disclosure, funding, or vesting requirements for the plan; they do not affect the calculation of benefits; and they are not common law rules designed to rectify faulty plan administration. (Citation omitted.) Similarly, plaintiffs are not employees resorting to state law to avail themselves of an alternative cause of action to collect benefits . . .

Id. at 1065.

Other circuits addressing the scope of the "relate to" clause align themselves with the Tenth Circuit in *Airparts*. *See, e.g., Perkins v. Time Ins. Co.*, 898 F.2d 470, 473 (5th Cir. 1990) (ERISA did not preempt an employee's claim against insurance agents for fraudulently misrepresenting a plan's coverage); *Perry v. P*I*E Nationwide, Inc.*, 872 F.2d 157 (6th Cir. 1989) (misrepresentation of the terms of a plan to induce participation was not preempted when Congress has not provided a remedy for the wrong and the employees' claims do not relate to any plan benefit), *cert. denied*, 493 U.S. 1093 (1990); *Aetna Life Ins. Co. v. Borges*, 869 F.2d 142, 146-47 (2d Cir.), *cert. denied*, 493 U.S. 811 (1989) ("What triggers ERISA preemption is not just any indirect effect on administrative procedures but rather an effect on the primary administrative functions of benefit plans, such as determining an employee's eligibility for a benefit and the amount of that benefit."); *Monarch Cement Co. v. Lone Star Indus.*, 982 F.2d 1448, 1452 (10th Cir. 1992), *citing Aetna Life*,

supra, ("[L]aws that have been ruled preempted are those that provide an alternative cause of action to employees to collect benefits protected by ERISA, refer specifically to ERISA plans and apply solely to them, or interfere with the calculation of benefits owed to an employee. Those that have not been preempted are laws of general application—often traditional exercises of state power or regulatory authority—whose effect on ERISA plans is incidental."); *Martori Bros. Distributors v. James-Massengale*, 781 F.2d 1349, 1356-57, (9th Cir.) (state law claims are not preempted unless they fall into one of four categories - "First, laws that regulate the type of benefits or terms of ERISA plans. Second, laws that create reporting, disclosure, funding, or vesting requirements for ERISA plans. Third, laws that provide rules for the calculation of the amount of benefits to be paid under ERISA plans. Fourth, laws and common-law rules that provide remedies for misconduct growing out of the administration of the ERISA plan." (citations omitted.)), *amended*, 791 F.2d 799, *cert. denied*, 479 U.S. 949 (1986); *Rebaldo v. Cuomo*, 749 F.2d 133, 139 (2d Cir. 1984) (where a state law does not affect the structure, the administration, or the type of benefits provided by an ERISA plan, the mere fact that the [law] has some economic impact on the plan does not require that the [law] be invalidated."), *cert. denied*, 472 U.S. 1008 (1985); *See also DiPietro-Kay Corp. v. Interactive Benefits Corp.*, 825 F. Supp. 459 (D. Conn. 1993) (employer's claims against insurer for negligence, misrepresentation and violation of Connecticut Unfair Trade Practices Act were not preempted by ERISA).

The denial of certiorari for circuit court cases on both sides of the diverging authority has only increased the uncertainty of the analysis being applied by the lower courts. The Supreme Court now has the opportunity to clear up this confusion after many circuits have considered the issue, with differing results.

ERISA Section 502(a) has been construed by courts to limit the remedies available to those expressly enumerated.[10] ERISA itself also provides no express remedies at all for a plan sponsor such as Tri-State - a further indication that Congress did not intend for preemption to apply to the sale of insurance.[11] Thus, section 502(a) provides civil remedies to a limited group of persons—namely, plan participants, beneficiaries and fiduciaries—*and* defines a limited number of categories of claims that may be asserted.

Importantly, the circuits are generally following this Court's holding[12] that remedies under ERISA are in fact limited to plan beneficiaries, participants or fiduciaries. *See, e.g., Hermann Hospital v. MEBA Medical & Benefits Plan*, 845 F.2d 1286, 1288-89 (5th Cir. 1988) ("Where Congress has defined the parties who may bring a civil action founded on ERISA, we are loathe to ignore the legislature's specificity."); *Pressroom Unions-Printers League Income Sec. Fund v. Continental Assurance Co.*, 700 F.2d 889, 892 (2d Cir.) ("legislature [did not]intend . . . to grant subject matter jurisdiction over suits by employers, funds, or other parties not listed in § 1132(a) . . . "), *cert. dismissed*, 464

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[10]*Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 54 (1987) ("The deliberate care with which ERISA's civil enforcement remedies were drafted and the balancing of policies embodied in its choice of remedies argue strongly for the conclusion that ERISA's civil enforcement remedies were intended to be exclusive.").

[11]In general, ERISA's civil enforcement provision grants plan participants and beneficiaries the right to bring a private action to recover benefits under a plan; to enforce ERISA's plan disclosure, funding, and administrative requirements; and to obtain "appropriate relief" for breach of fiduciary duty by an ERISA plan administrator or other person who exercises discretionary control or authority over the plan or its assets. *See* 29 U.S.C. § 1132(a).

[12]In *Franchise Tax Bd. v. Construction Laborers Vacation Trust*, 463 U.S. 1 (1983), this Court stated that "[t]he express grant of federal jurisdiction in ERISA is limited to suits brought by certain parties . . . as to whom Congress presumably determined that a right to enter a federal court was necessary to further the statute's purposes." *Id.* at 21.

U.S. 845 (1983); *Whitworth Bros. Storage Co. v. Cent. States Pension Fund,* 794 F.2d 221, 228 (6th Cir.) (employer could not maintain suit under ERISA because "Congress intended to limit the parties who could maintain actions pursuant to [ERISA] section 502, [and] that section 502 is an exclusive grant of jurisdiction."), *cert. denied,* 479 U.S. 1007 (1986).

Thus, the Fourth Circuit has found that ERISA preempts Tri-State's state law claims notwithstanding the fact that Tri-State is not authorized by ERISA to institute an action and despite the fact that ERISA contains no remedial provisions addressing the fraud or bad faith of an insurance company vis-a-vis an employer/plan sponsor.

Again, there is no question that the scope of ERISA preemption is broad. Also, there *is* a sound basis for courts to hold that the saving clause of ERISA does not permit plan *participants and beneficiaries* from grafting state insurance law rights and remedies onto ERISA, since ERISA strikes a delicate balance between the interest of participants versus the societal interest in encouraging employers to create plans. But while ERISA has detailed provisions regarding the rights and remedies of plan beneficiaries and participants, ERISA does not have express provisions providing remedies for employers who are non-fiduciary plan sponsors.

The Court is now presented with the opportunity to stop the unnecessary expansion of federal common law by courts like the Fourth, Eighth and Eleventh Circuits. The "relate to" clause is properly viewed expansively when Section 502(a) enumerated parties institute suit, because ERISA provides a remedy to such parties. However, as illustrated by the Second, Fifth, Sixth, Ninth and Tenth Circuit cases discussed above, the "relate to" clause should not be viewed expansively when non-enumerated parties such as Tri-State, a non-fiduciary plan sponsor, institute suit.

Because ERISA does not provide a remedy for misrepresentation or other fraudulent acts committed in connection with the sale of insurance and the computation of insurance premiums, this case gives rise to the issues of whether the dispute "relates to" an ERISA plan in the first instance and whether it is appropriate for courts to create federal common law to replace state law governing disputes not addressed by ERISA. Similarly, this case gives rise to the analogous issue of whether actions can be brought by *parties* not identified in ERISA Section 502(a) (*i.e.*, plan sponsors who are not participants, beneficiaries or fiduciaries) and, if so, whether such actions must be pursued under ERISA, federal common law or under state law.

These are important issues that have important ramifications for all employers who provide welfare benefits to their employees through the purchase of insurance, who are considering doing so, or who may be forced to do so if employer-benefits are mandated.

B. Judicial Construction of the "Saving Clause".

The conflicting interests in allowing states to regulate areas of traditional state law concern versus the need for exclusive federal regulation of employee benefits comes to a head in construing the saving clause of ERISA's preemption provision. Following this Court's lead in *Pilot Life*, it appears to be well accepted in all of the circuits that claims asserted *by participants or beneficiaries* under state law, even state insurance law, are preempted because inevitably they strike at the core concern of ERISA - to provide a uniform and limited remedial scheme. On the other hand, where claims are asserted by persons other than participants or beneficiaries, such as in the case at bar, the courts are split.

In cases involving beneficiaries seeking to invoke state insurance laws to enhance their remedies, this Court has suggested looking, first, to the common sense understanding of the term "regulates insurance" and, second, to the McCarran-Ferguson Act test to determine whether the law regulates the business of insurance. *See, e.g., Metropolitan Life, supra,* and *Pilot Life, supra.*[13] In *Pilot Life,* this Court found that bad faith insurance claims asserted by a plan participant are not insurance regulations of the type that Congress intended to save. Although this Court obviously intended the McCarran-Ferguson Act test to assist courts in distinguishing core insurance concerns from remedies that conflict with the interests embodied by ERISA, the test is not well-suited for addressing the application of preemption to parties not enumerated in ERISA Section 502(a) and has been used to severely limit the scope of the saving clause. Consequently, preemption has been extended into areas not addressed by ERISA.

For example, in the case at bar, the Fourth Circuit perfunctorily applied the McCarran-Ferguson test (without first considering the common sense test) and reached the conclusion that Congress intended to displace state law that would otherwise provide an *employer* with remedies against an insurance company from whom the employer purchased insurance.

On the other hand, where an employer brought suit against an insurance company for failing to ensure that a policy conformed to the requirements of state law, the Sixth Circuit ruled

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[13]In *Metropolitan Life Ins. Co. v. Massachusetts,* 471 U.S. 724 (1985), this Court referenced a test developed under the McCarran-Ferguson Act, 15 U.S.C. § 1011 *et seq.,* to guide courts in determining whether state laws regulate insurance: "first, whether the practice has the effect of transferring or spreading a policyholder's risk; second, whether the practice is an integral part of the policy relationship between the insurer and the insured; and third, whether the practice is limited to entities within the insurance industry." *Id.* at 743 (quoting *Union Labor Life Ins. Co. v. Pireno,* 458 U.S. 119, 129 (1982)).

that pertinent state insurance law was saved from preemption because state insurance law applied to insurance policies purchased by ERISA plans. *Int'l Resources, Inc. v. New York Life Ins. Co.*, 950 F.2d 294, 300 (6th Cir.), *cert. denied*, ___ U.S. ___, 112 S.Ct. 2941 (1992).

The Fourth Circuit's ruling in the case at bar is in direct conflict with the Sixth Circuit and is typical of the collective failure of the lower courts to scrutinize this Court's guidance. *See FMC Corp. v. Holliday*, 498 U.S. 52, 64 (1990) ("the saving clause retains the independent effect of protecting state insurance regulation of insurance contracts purchased by employee benefit plans.")

C. Judicial Construction of the "Deemer Clause."

The saving clause states that "any law of any State which regulates insurance, banking, or securities" is saved from ERISA preemption. ERISA Section 514(b)(2)(A). The deemer clause limits the effect of the saving clause and states that no employee benefit plan "shall be deemed to be an insurance company or other insurer . . . or . . . engaged in the business of insurance . . . for purposes of any law of any state purporting to regulate insurance companies [or] insurance contracts." ERISA Section 514(b)(2)(B).

The deemer clause has been interpreted by the Supreme Court to exempt "ERISA plans from state laws that 'regulat[e] insurance' within the meaning of the saving clause." *FMC Corp. v. Holliday*, 498 U.S. 52, 61 (1990).

> State laws that directly regulate insurance are "saved" but do not reach self-funded employee benefit plans because the plans may not be deemed to be insurance companies, other

> insurers, or engaged in the business of insurance for purposes of such state laws. *On the other hand, employee benefit plans that are insured are subject to indirect state insurance regulation.* An insurance company that insures a plan remains an insurer for purposes of state laws "purporting to regulate insurance" after application of the deemer clause. *The insurance company is therefore not relieved from state insurance regulation.* The ERISA plan is consequently bound by state insurance regulations insofar as they apply to the plan's insurer.

Id. (emphasis added). If the foregoing statements were not sufficiently clear, this Court concluded its analysis in *FMC Corp.* by stating that "[o]ur interpretation of the deemer clause makes clear that *if a plan is insured, a State may regulate it indirectly through regulation of its insurer and its insurer's insurance contracts;* if the plan is uninsured, the State may not regulate it." *Id.* at 64 (emphasis added).

This guidance from the Court provides two important dictates that are not being followed by the lower courts throughout the United States. First, lower courts should not extend deemer clause protection to insurance companies. Clearly, the deemer clause prohibits *plans* from being deemed insurers or engaged in the business of insurance. Obviously, insurance companies are insurers and ought to be governed by state insurance law.

Second, the lower courts are ignoring the Court's mandate that only self-funded plans escape state insurance regulation. The common sense concept of a self-funded plan is a plan that contains no insurance. Lower courts and the Fourth Circuit, in particular, however, are extending application of the deemer clause to plans having insurance.

1. Erroneous application to insurance companies.

Although the deemer clause is obviously intended to relieve employee benefit plans from state insurance laws, the clause has been used by insurance companies to avoid the application of state insurance laws to the sale of their insurance policies. Nationwide sold an insurance policy to Tri-State. As noted by Judge Luttig in his dissenting opinion in this case, the sale of the insurance policy and the computation of premiums due were clearly *not* made by the Tri-State benefit plan. It is plain that Tri-State is seeking to hold Nationwide, not the benefit plan, accountable for Nationwide's fraudulent conduct in violation of West Virginia's insurance laws. Tri-State is not seeking to deem the Tri-State benefit plan to be an insurance company.

Nevertheless, the Fourth Circuit majority found, from a review of the plan documents, that Tri-State's benefit plan was "a self-funded one for the most part . . . Accordingly, the district court correctly held that the plan was self-funded and that the Deemer Clause of ERISA would also apply to preempt Tri-State's claims." *Tri-State Machine, Inc. v. Nationwide Life Ins. Co.*, 33 F.3d 309, 315 (4th Cir. 1994). Having incorrectly concluded that the plan was self-funded, the Fourth Circuit ruled that the deemer clause applied without considering the identity of the defendant—an insurer. This case presents the Court with the opportunity to clarify application of the deemer clause by holding that plan sponsors asserting premium-related causes of action are not seeking to hold the employee benefit plan accountable for a breach of state insurance law (consequently, the deemer clause is completely inapplicable).

Consistent with *FMC Corp.*, Tri-State is seeking to enforce state insurance regulation of Nationwide, not the Tri-State benefit plan. *FMC Corp.* permits state regulation of companies that insure ERISA plans. The deemer clause relieves ERISA benefit

plans—both insured and uninsured plans—from direct state regulation. The deemer clause does not relieve the plan's insurer from regulation by state law.

2. What is a self-funded plan?

Notwithstanding this Court's decision in *FMC Corp.*, the circuits are split as to when a plan is "self-funded" so as to trigger application of the deemer clause. Some courts have recognized that the deemer clause should be narrowly construed so that employers who transfer risk to insurance companies for the purpose of limiting their own exposure may be protected by state insurance laws. These cases recognize that a self-funded plan, by definition, is not insured.

Another line of cases, however, has broadly construed the deemer clause to mean that an employer who retains some risk through a partially funded plan is precluded from invoking state insurance laws. In particular, the Fourth Circuit, as discussed below, views a self-funded plan as a plan that receives *some* claims reimbursement from the employer (through increased premium obligations).

The issue which must be decided then, and which is of huge importance to all insurance companies and all employers who sponsor health care plans, is whether insurance companies are exempt from state insurance laws where an employer funds some portion of the health care plan. It is Tri-State's contention that this area of law desperately needs a bright line rule stating that insurance companies are subject to state insurance laws in all situations where they are insuring employers against any risk in connection with the sponsorship of an ERISA plan.

The Fourth Circuit has twice applied the deemer clause to plans that were insured. In the instant case, the court reviewed the plan documents and found that Tri-State's benefit plan was "a self-funded one *for the most part*" and applied the deemer

clause to prevent the "saving" of any state law causes of action. *Tri-State Machine*, 33 F.3d at 315 (emphasis added). As explained in the Statement of the Case herein, Nationwide provided insurance to Tri-State and was liable for all claims over specified dollar amounts.

Also, in *Hampton Industries, Inc. v. Sparrow*, 981 F.2d 726 (4th Cir. 1992), the Fourth Circuit applied the deemer clause to a plan that was merely responsible for claims up to $60,000 per year/per employee. The employer purchased insurance from Blue Cross/Blue Shield which required Blue Cross/Blue Shield to pay for any claims over the self-funded amount. *Id.* at 727, n.1. In the insurance industry, this arrangement is known as "stop loss" insurance.

Other circuits, in contradiction to the Fourth Circuit, recognize that the presence of insurance *ipso facto* negates the possibility that a plan is self-funded. In *Northern Group Services, Inc. v. Auto Owners Ins. Co.*, 833 F.2d 85 (6th Cir. 1987), *cert. denied*, 486 U.S. 1017 (1988), the Sixth Circuit was faced with determining whether certain employee benefit plans were self-insured. Without deciding whether the insured party was the employee benefit plan or the employer, the court noted that insurance proceeds would be payable only when claims exceeded specified ceilings. Consequently, the particular employee benefit plan at issue was not self-insured. *Id.* at 91.[14]

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[14]*Northern Group* was later limited in its holding. In *Lincoln Mut. Casualty Co. v. Lectron Products, Inc. Employee Health Plan*, 970 F.2d 206 (6th Cir. 1992), the Sixth Circuit ruled that a self-funded benefit plan which purchased stop loss insurance to cover its own catastrophic losses remained a self-funded plan. *Lincoln Mutual* did not involve an employer's purchase of insurance as does the case at bar.

This area of law begs for guidance recognizing that employers who purchase an insurance contract to fund an employee benefit plan may require the insurance company to comply with the dictates of state insurance law.

CONCLUSION

The implications of the matters at issue in this appeal are expansive, especially in this age of calls for health care reform and demands for employer-sponsored health care. Tri-State bargained for insurance to shift its risk and burden of providing health care benefits. What it received in return was insurance fraud.

The plain language of ERISA indicates that it was not designed to protect insurance companies from complying with insurance regulations, and most certainly not from breach of contract and tort claims arising out of fraudulent billing practices unrelated to benefits administration.

There are several reasons why the issues in this lawsuit merit the attention of the Supreme Court, especially at this point in time. First, a trend has swept the country's courts, developed from the early preemption cases decided by this Court, to interpret the force of ERISA preemption more and more broadly so as to cover transactions and parties that Congress never intended. Second, the analysis performed to determine the breadth of ERISA's preemptive effect needs to be retooled. Presently the "relates to" analysis is not a test at all, because it knows no bounds. Third, the saving and deemer clause analysis has been modeled after an old insurance law standard that has simply not been workable or meaningful outside of the beneficiary or participant context of preemption analysis. The net effect of this is to gut state insurance laws as they may apply to employer-sponsored health coverage.

Finally, and most importantly, the strong interest in having employers create and continue ERISA welfare plans has been undermined by the misapplication of preemption analysis. When employers should be encouraged to create plans by, for example, buying health insurance for their workers, they are actually discouraged from doing so by the present interpretation of ERISA which permits insurance companies to sell insurance policies to employers without accountability under state insurance laws.

Respectfully submitted,

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APPENDIX

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF WEST VIRGINIA

ORDER FILED
SEPTEMBER 23, 1991

TRI-STATE MACHINE, INC.,
Plaintiff,

Vs. CIVIL ACTION NO 90-0027-W(K)

NATIONWIDE LIFE INSURANCE COMPANY,

Defendant.

MEMORANDUM OPINION AND ORDER

Currently pending is the plaintiff's motion for partial summary judgment. Defendant has filed its opposition, as well as a motion to strike plaintiff's motion. No reply has been filed by the plaintiff. Said matters are now ripe for disposition.

The material facts underlying this matter are not in dispute. From November of 1983 through July of 1987, Tri-State Machine, Inc. ("Tri-State") contracted with Nationwide Life Insurance Company ("Nationwide") for group health insurance for Tri-State's employees. After July of 1987, Tri-State became self-insured for health benefits to its employees, with Nationwide providing stop-loss insurance as well as providing administrative claims processing functions. During July of 1989, the relationship between the parties terminated.

Tri-State then commenced this civil action in state court against Nationwide asserting common law breach of contract claims and statutory claims under West Virginia law. Nationwide removed the action to this Court, basing jurisdiction upon

OPINION

NIEMEYER, Circuit Judge:

We are presented with the issue of whether the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001, *et seq.*, preempts state law claims of Tri-State Machine, Inc., for improper claims processing and mismanagement against Nationwide Life Insurance Company. Nationwide Life issued and administered a group insurance policy to provide health care benefits for Tri-State's employees under an employee benefit plan. The district court ruled that Tri-State's state law claims were preempted by ERISA and, upon Tri-State's failure to amend its complaint to state a claim under ERISA, dismissed the action. Tri-State contends on appeal that it is a "mere purchaser" of insurance and that its claims against Nationwide Life are not preempted by ERISA because they do not "relate to" an employee benefit plan. Tri-State also contends that its claims are based on state laws regulating insurance, which are saved from preemption under § 514(b)(2)(A) of ERISA. For the reasons that follow, we conclude that the district court properly held that all of Tri-State's state law claims are preempted by ERISA and affirm.

I

The employee benefit plan of Tri-State Machine, Inc., provides medical, disability, dental, and death benefits to Tri-State employees and their beneficiaries. The terms of the plan give participants notice that the plan is governed by ERISA and that they are entitled to certain rights and protections under ERISA. Until 1989, the plan was insured and administered by Nationwide Life Insurance Company under a group policy and under a Cash Priority Plan Funding Agreement between Nationwide Life and Tri-State. Under the agreement, claims for benefits were self-funded by Tri-State up to a $25,000 limit for each employee

for each year, beyond which Nationwide Life agreed to pay claims under stop-loss insurance. All claims by employees were to be submitted to Nationwide Life, who reserved the right to determine whether the claims were payable. Nationwide Life provided monthly reports to Tri-State detailing Tri-State's liability under the agreement. Nationwide Life entered into a subcontract with First Benefits Agency, Inc., to administer the plan.

Effective July 1, 1989, Nationwide Life terminated its arrangements with Tri-State. Alleging that Nationwide Life mismanaged and improperly carried out its claims processing responsibilities under the policy and agreement, Tri-State filed suit in the West Virginia Circuit Court of Ohio County in February 1990, alleging breach of contract, breach of implied covenants of good faith and fair dealing, bad faith tort, insurance bad faith, and violation of the West Virginia Unfair Trade Practices Act, W. Va. Code §§ 33-11-1 through 33-11-10. Tri-State asserted that Nationwide Life failed to administer the plan according to the terms of the agreement and mismanaged the claims processing procedures by paying claims to wrong medical providers, by issuing coverage cards in the names of employees never associated with Tri-State, by charging claims to accounts of individuals who had not submitted claims, by paying claims not covered, by denying claims that were covered, and by requesting reimbursement from Tri-State for claims improperly paid. Tri-State also charged that Nationwide Life delayed processing of claims in a year during which Tri-State had met its stop-loss liability, deflecting claims into a new policy year so that claims would become the obligations of Tri-State by reason of the annual self-funding limit of $25,000 for each employee.

Nationwide Life removed the case to the federal district court on diversity grounds and also on grounds that the claims were preempted by ERISA. On Tri-State's motion for partial summary judgment to declare that ERISA did not preempt its

state law claims, the district court denied the motion and held that "ERISA preempts all of Tri-State's claims based upon West Virginia laws relating to the health insurance plan upon which its complaint is based." The court held specifically that 29 U.S.C. § 1144(a) preempts all of Tri-State's claims and that the exception to preemption contained in 29 U.S.C. § 1144(b)(2)(A), known as the Savings Clause, did not apply because the "Deemer Clause," contained in § 1144(b)(2)(B), excludes from the Savings Clause self-funded benefit plans. The court found that the plan in this case was a self-funded plan and that the stop-loss insurance for coverage above the self-funded amounts did not "change this outcome." Thereafter the court ordered Tri-State to notify the court whether it intended to pursue the case under ERISA. Although Tri-State indicated its intention to do so, it never amended its complaint to state a claim under ERISA, and the district court dismissed the complaint. This appeal followed.

II

We are presented with the legal issue of whether Tri-State's state law claims, arising out of allegedly wrongful claims processing by Nationwide Life, are preempted by ERISA. Since the question is one of law, we will review the district court's orders *de novo*.

ERISA's preemption clause provides:

> Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar *as they may now or hereafter relate to any employee benefit plan* . . . .

29 U.S.C. § 1144(a) (emphasis added). This clause has been broadly interpreted by the courts to carry out Congress' intent to displace any state law efforts to regulate ERISA matters. *See,*

e.g., FMC Corp. v. Holliday, 498 U.S. 52, 58 (1990) ("the preemption clause is conspicuous for its breadth"); *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 98 (1983) ("the section's preemptive scope [is] as broad as its language"); *Custer v. Pan American Life Ins. Co.*, 12 F.3d 410, 418 (4th Cir. 1993) ("it is frequently observed that the force of ERISA's preemption is strong and its scope wide"). Thus, any law "that relates to" a plan is preempted by 29 U.S.C. § 1144(a), and the phrase "relates to" is given its common sense meaning as having "connection with or reference to such a plan." *Shaw,* 463 U.S. at 96-97.

Although ERISA's preemptive sweep is broad, the "Savings Clause" contained in 20 U.S.C. § 1144(b)(2)(A), which saves from preemption state laws that regulate insurance, is stated almost as broadly. This clause preserves for state regulation any law "which *regulates insurance* banking, or securities." 29 U.S.C. § 1144(b)(2)(A) (emphasis added). In *Metropolitan Life Ins. Co. v. Massachusetts,* 471 U.S. 724, 739-40 (1985), the Supreme Court construed the Savings Clause to apply only to state laws regulating core insurance issues. Considering a complex state statutory scheme which regulated, among other things, the substantive content of health insurance policies, the Supreme Court held that state insurance regulations that mandate particular policy benefits are saved from preemption by the Savings Clause. It concluded that Congress intended to save from preemption only those state laws that regulate the traditional business of insurance to the extent that it involves contractual arrangements for protection against financial loss through the spreading of risk. To guide this inquiry, the Court put forth the following three-part test developed under the McCarran-Ferguson Act:

> *[F]irst,* whether the practice has the effect of transferring or spreading a policyholder's risk; ***second,*** whether the practice is an integral part of the policy relationship between the insurer and the insured; and ***third,*** whether the practice is limited to entities within the insurance industry.

471 U.S. at 743 (quoting *Union Labor Life Ins. Co. v. Pireno,* 458 U.S. 119, 129 (1982)). Thus, a claim based on state law or regulation that regulates the business of insurance as defined by *Metropolitan Life's* three-part test is "saved" from preemption by virtue of the Savings Clause, § 1144(b)(2)(A), even if the claim "relates to" an employee benefit plan within the meaning of § 1144(a).

ERISA takes the further step of limiting the Savings Clause by stating that an employee welfare benefit plan itself is not, under state law, to be "deemed" an insurance company for purposes of the Savings Clause. This so-called "Deemer Clause" provides:

> *Neither an employee benefit plan* . . . nor any trust established under such a plan, *shall be deemed to be an insurance company,* or other insurer . . . or to be engaged in the business of insurance or banking for purposes of any law or [sic] any State purporting to regulate insurance companies, insurance contracts . . . .

29 U.S.C. § 1144(b)(2)(B) (emphasis added). The Deemer Clause has been interpreted by the Supreme Court "to exempt self-funded ERISA plans from state laws that 'regulat[e] insurance' within the meaning of the saving clause." *FMC Corp. v. Holliday,* 498 U.S. at 61. The Court reasoned that "[b]y forbidding States to deem employee benefit plans 'to be an insurance company or other insurer . . . or to be engaged in the business of insurance,' the deemer clause relieves plans from state laws purporting to regulate insurance.' " *Id.* Thus, "[s]tate laws that directly regulate insurance are 'saved' but do not reach self-

funded employee benefit plans because the plans may not be deemed to be insurance companies, other insurers, or engaged in the business of insurance for purposes of such state laws." *Id.*

While *Metropolitan Life* placed state insurance regulations mandating particular insurance policy benefits within the area preserved for state regulation, the Supreme Court in *Pilot Life Ins. Co. v. Dedeaux,* 481 U.S. 41 (1987), held that state insurance law regulating *claims processing* did not regulate the "business of insurance" and therefore, was not saved from preemption. In *Pilot Life,* an injured employee sued the insurance company that issued and administered his employer's disability plan, asserting improper acts in connection with the processing of a claim for benefits. The suit was based on state common law tort and contract principles. The Supreme Court concluded as a first step that "common law causes of action raised in Dedeaux's complaint, each based on alleged improper processing of a claim for benefits under an employee benefit plan, undoubtedly meet the criteria for pre-emption under § 514(a) [29 U.S.C. § 1144(a)]." *Id.* at 48. The Court then proceeded to determine whether such claims against an insurance company for improper claims processing fell within the Savings Clause. Applying the test of *Metropolitan Life,* the Court concluded that such claims were not made under state laws regulating the core insurance business and therefore were not saved by the Savings Clause. Consequently, the state law claims were held to be preempted. 481 U.S. at 57.

In *Custer v. Pan American Life, supra,* we applied the *Pilot Life* holding to conclude that the West Virginia Unfair Trade Practices Act, which regulates insurance companies by prohibiting certain unfair trade and settlement practices, was not saved from preemption. Accordingly, we held that claims made under the West Virginia law relating to an insurance company's improper claims processing or administration of an employee

benefit plan were preempted. The West Virginia Supreme Court, also relying on *Pilot Life*, had earlier reached the same conclusion. *See Ball v. Life Planning Services, Inc.*, 421 S.E.2d 223, 227 (W. Va. 1992) (holding that an action under subsection 9 of West Virginia Code 33-11-4 is preempted under ERISA). *See also Powell v. Chesapeake & Potomac Telephone Co.*, 780 F.2d 419, 423-24 (4th Cir. 1985), *cert. denied*, 476 U.S. 1170 (1986) (concluding, in a case decided before *Pilot Life* but consistent with it, that an action alleging improper claims processing is not saved from preemption because it does not regulate the business of insurance under ERISA).

With these principles in mind, we turn to the issues before us.

III

Tri-State contends that the state law claims alleged in its complaint are not preempted by ERISA, relying on two different theories. First, it argues that it is a "mere purchaser" of insurance and that therefore the claims arising from its status as a mere insurance purchaser are not "related to" an employee benefit plan within the preemption clause of ERISA, 29 U.S.C. § 1144(a). Tri-State also argues that since its claims arise under the West Virginia Unfair Trade Practices Act, which regulates insurance companies, they are preserved to state regulation under the Savings Clause of ERISA, 29 U.S.C. § 1144(b)(2)(A). To support its second argument, Tri-State points to W. Va. Code § 33-11-1, which states that the purpose "of this article . . . [is] to regulate trade practices *in the business of insurance*" (emphasis added).

Tri-State's first argument will not detain us long, since the broad sweep of 29 U.S.C. § 1144(a) provides for preemption of claims under any state law that "relate to any employee benefit plan." No serious argument is made that the package of health

care benefits provided by Tri-State to its employees through the policy purchased from Nationwide Life is not a plan. In addition to the fact that the plan's language announces participants' rights under ERISA, the nature of the arrangement, which provides benefits paid for by the employer to employees and their beneficiaries in connection with their employment, meets the criteria defining a plan under ERISA. *See* 29 U.S.C. § 1002(1); *Custer*, 12 F.3d at 417.

Moreover, there can be little doubt that the claims relate to the plan. Tri-State's complaint particularizes a list of wrongs committed by Nationwide Life, including its paying claims to wrong medical providers, issuing coverage cards in the names of employees never associated with Tri-State, charging claims to accounts of individuals who had not submitted claims, paying claims not covered, denying claims that were covered, and delaying processing of claims in a year when the stop-loss limit had been reached in order to deflect them into a new policy year to be charged against Tri-State under its self-funding obligations. All of these allegations are essentially complaints about the processing of claims under an employee benefit plan and, therefore, *relate to* the plan in the common sense meaning of that phrase. Indeed the Supreme Court in *Pilot Life* specifically stated: "The common law causes of action raised in *Dedeaux's* complaint, *each based on alleged improper processing of a claim* for benefits under an employee benefit plan, undoubtedly meet the criteria for preemption under § 514(a)." 481 U.S. at 48 (emphasis added). *See also Custer*, 12 F.3d at 420.

Concluding that Tri-State's claims relate to an employee benefit plan and thus fall under ERISA's broad preemption provision of 29 U.S.C. § 1144(a) does not, however, end the inquiry. Tri-State's second argument is that because its claims fall under the West Virginia Unfair Trade Practices Act, W. Va. Code §§ 33-11-1 through 33-11-10, establishing unfair trade

practices in the business of insurance, its state law claims are preserved from federal preemption under the Savings Clause. The question thus presented is whether the trade practices identified in the West Virginia Act regulate the business of insurance as that phrase is used in ERISA, 29 U.S.C. § 1144(b)(2)(A), and interpreted in *Metropolitan Life,* 471 U.S. at 743 (establishing the three-prong test for determining whether a state law regulates the *business of insurance*).

The Unfair Trade Practices Act, Article 11 of the Insurance chapter of the West Virginia Code, specifically attempts to place itself within the meaning of "business of insurance" as defined by the McCarran-Ferguson Act, 15 U.S.C. § 1011, *et seq.* The first section of the article states:

> The purpose of this article is to regulate trade practices in the business of insurance in accordance with the intent of Congress as expressed in the act of Congress of March ninth, one thousand nine hundred forty five (Public Law fifteen, seventy-ninth Congress) [the McCarran-Ferguson Act], by defining, or providing for the determination of, all such practices in this State which constitute unfair methods of competition or unfair or deceptive acts or practices and by prohibiting the trade practices so defined or determined.

W. Va. Code § 33-11-1. Since the term "business of insurance" in the McCarran-Ferguson Act has been adopted as the basis for defining the scope of the Savings Clause of ERISA, *Metropolitan Life,* 471 U.S. at 743, Tri-State argues that the West Virginia regulation of insurance fits into the exception to ERISA's broad preemption, even though the West Virginia Act, having been enacted before the federal statute, is not adopted in response to ERISA. Although the argument has some logical appeal, further analysis reveals a superficiality that fails to take into account the substance of the Unfair Trade Practices Act.

The Act provides a long list of prohibited acts in the marketing, selling, and administering of insurance in West Virginia. It prohibits false or misleading statements or advertising as to the contents of a policy and also prohibits engaging in unfair settlement practices, in an apparent effort to provide truth in insurance advertising and fairness in insurance administration. *See, e.g.*, W. Va. Code §§ 33-11-3 & 33-11-4. The Act prohibits many of the practices alleged by Tri-State in its complaint to constitute improper claims processing. But this type of regulation is not unique to the business of insurance, and it does not target, at least in these provisions, the core business of insurance which involves contracts of protection under which risk is spread among policy holders.

We recently interpreted this precise statute and concluded that since the West Virginia Unfair Trade Practices Act does not simply regulate the business of insurance as defined in *Metropolitan Life*, it is not saved from preemption in connection with claims relating to an employee benefit plan. *See Custer*, 12 F.3d at 419-421. In *Custer*, an insurance company issued a policy to an employer and administered it as part of an employee benefit plan. When the plaintiff sued the insurance company for denying benefits and canceling the policy, allegedly in violation of West Virginia law, we concluded that the claims were preempted, holding "that Custer's claims under West Virginia law relating to improper claims processing or administration are not saved from preemption by the savings clause." 12 F.3d at 420. We concluded that our decision was directly controlled by the Supreme Court's holding in *Pilot Life*, 481 U.S. at 50 (holding that state law improper claims processing actions are not directed at the insurance industry alone and do not relate to the spreading of risk), and this court's holding in *Powell*, 780 F.2d at 423-24 (concluding that an action alleging improper claims processing is

not saved from preemption because it does not regulate the business of insurance under ERISA).

The holding in *Custer* applies here to require a determination that Tri-State's claims are also not saved from preemption under § 1144(b)(2)(A). *See also Ball v. Life Planning Services, Inc.*, 421 S.E.2d 223, 227 (W. Va. 1992) (holding that West Virginia Code § 33-11-4(9) relates to unfair claims settlement practices and therefore is the same type of claim that the Supreme Court found to be preempted by ERISA in *Pilot Life).*

The district court also found an alternative basis to hold that Tri-State's state law claims were preempted. It concluded that even if Tri-State's claims fell within the Savings Clause, the employee benefit plan involved here would be regulated by ERISA, and not state law, under the Deemer Clause. The district court concluded that the group health insurance plan issued by Nationwide Life and sponsored by Tri-State was a self-funded plan, and thus under the Deemer Clause of ERISA, it was not subject to regulation under state law purporting to regulate the business of insurance. *See FMC Corp.*, 498 U.S. at 61. It appears from our review of the plan documents that the plan was indeed a self-funded one for the most part, with stop-loss insurance to cover an individual's claims in excess of $25,000. Tri-State's complaint alleges as much: "Under the policy, Tri-State was self-insured for certain portions of benefits payable under the group health insurance plan." Complaint ¶8. We have held previously that the purchase of stop-loss insurance does not convert a self-funded plan to an insured plan for preemption purposes. *See Thompson v. Talquin Building Products Co.*, 928 F.2d 649, 653 (4th Cir. 1991). Accordingly, the district court correctly held that the plan was self-funded and that the Deemer Clause of ERISA would also apply to preempt Tri-State's claims.

IV

Finally, Tri-State contends that the district court "improperly dismissed Tri-State's suit in its entirety because Tri-State's complaint must necessarily state a cause of action under ERISA or federal common law." The difficulty with the contention is the underlying assumption that somehow Nationwide Life or the district court was required to identify and define Tri-State's claim when Tri-State itself refused to do so over a two-year period. The district court carefully reviewed the procedural steps taken by Tri-State and concluded, in essence, that Tri-State simply failed to prosecute its case under ERISA. On a review of the record, we cannot say that the district court abused its discretion in bringing this tortured pleading battle to an end.

After the case was removed from state court on the basis of diversity jurisdiction and ERISA preemption, Tri-State sought to remand the action. When the district court denied its motion, Tri-State filed a motion for partial summary judgment declaring that ERISA did not preempt Tri-State's state law claims. By a Memorandum Opinion and Order dated September 23, 1991, the district court concluded that the state law claims were preempted and denied Tri-State's motion to declare otherwise. Shortly thereafter, Tri-State filed a motion for reconsideration and requested, alternatively, that the court make the necessary finding to permit it to seek appellate review under 28 U.S.C. § 1292(b). The district court denied the motion for reconsideration, observing that nothing new had been presented by Tri-State, but it did give Tri-State the opportunity to seek leave to appeal under 28 U.S.C. § 1292(b). In its petition for permission to appeal, Tri-State claimed that its case was "simply a breach of contract and an independent tort case" and "Never did the plaintiff [Tri-State] intend to involve, nor does the complaint affect, ERISA issues." When this court summarily denied permission to appeal, Tri-State petitioned the district court to vacate and re-

enter its order denying reconsideration of its ERISA preemption ruling, believing that Tri-State's late filing of a petition to appeal was the basis for denial of permission. The district court refused Tri-State's request and ordered that Tri-State inform the court whether it intended to pursue an action under ERISA. On June 8, 1992, plaintiff filed a notice in which it informed the court that Tri-State "intends to pursue this action under ERISA." Tri-State, however, did not file an amended complaint to state any claim under ERISA. Rather, over five months later, it filed another motion to obtain from the court a certification under Federal Rule of Civil Procedure 54(b) that the district court's preemption ruling was final. At that time, Tri-State again argued the preemption issue and sought to amend three paragraphs of its complaint to enhance its effort to circumvent ERISA preemption. The amendments sought were not substantive and would only have altered Tri-State's characterization of the parties' roles. Because Tri-State failed to prosecute the case through the filing of an ERISA claim, and only pursued alternative avenues to challenge the district court's ruling, the district court concluded, again reviewing the merits of the preemption issue:

> In that this issue [ERISA preemption] has been repeatedly and exhaustively briefed, in that Tri-State has fully defended and has presented all material pertinent to its claim, and since Tri-State has failed to seek leave to amend its complaint to assert an ERISA claim, the Court hereby GRANTS summary judgment *sua sponte* for Nationwide, and hereby DISMISSES this action.

Against this procedural history, the district court had a well-founded basis to conclude that Tri-State was only interested in obtaining appellate review of the preemption issue and that, by not pursuing an ERISA claim, Tri-State was staking the success of its action solely on the question of whether its state law claims survived. The district court's decision to dismiss the complaint in

these circumstances was not an abuse of discretion. Accordingly, we affirm.

AFFIRMED

LUTTIG, Circuit Judge, dissenting:

The majority holds that the unfair trade practices article of the West Virginia insurance code, which was enacted "to regulate trade practices in the business of insurance," W. Va. Code § 33-11-1, is not a state "law . . . which regulates insurance," 29 U.S.C. § 1144(b)(2)(A). Thus, it concludes, Tri-State's improper claims processing action under that statute is not saved from preemption. According to the majority, this result is dictated by our recent decision in *Custer v. Pan American Life Ins. Co.*, 12 F.3d 410 (4th Cir. 1993), in which we interpreted the Supreme Court's decision in *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987), as holding that all state improper claims processing actions filed against an insurance company are not saved from preemption. In my view, *Pilot Life* did not sweep quite so broadly, and applying here the saving clause analysis undertaken by the Supreme Court in *Pilot Life* requires us to hold that Tri-State's state action *is saved* from preemption. Accordingly, I dissent.

In *Pilot Life*, the Supreme Court addressed whether ERISA preempts a beneficiary's or participant's cause of action for improper claims processing brought under Mississippi's common law of bad faith, holding that the action was not saved from preemption under ERISA's "saving clause," 29 U.S.C. § 1144(b)(2)(A). In reaching this conclusion, the Court first determined that a "common-sense understanding" of the language of the saving clause confirms that a state law only "regulates insurance" when it is "specifically directed toward th[e insurance] industry." 481 U.S. at 50. Applying this common-sense understanding of the clause's text, it concluded that the

Mississippi common law of bad faith does not regulate insurance, because it is rooted in general principles of Mississippi tort and contract law. *Id.* It next reviewed Mississippi's bad faith doctrine under the three criteria the Court employs to interpret the McCarran-Ferguson Act, 15 U.S.C. § 1011 *et seq.*, and found that these factors also did not support a conclusion that the Mississippi law "regulates insurance." 481 U.S. at 50-51. And finally, the Court looked to the "role of the saving clause in ERISA as a whole," *id.* at 51, concluding that Congress intended as exclusive the civil remedies that ERISA provides to *beneficiaries and participants* alleging improper claims processing. *Id.* at 52-57.

Only last term, in *Custer*, we considered whether ERISA preempted a beneficiary's improper claims processing action brought under West Virginia's insurance code, *see* W. Va. Code § 33-11. In that case, we assumed, mistakenly I believe, that *Pilot Life* broadly held that all "state cause[s] of action for improper claims processing filed against an insurer [are] not saved from preemption under § 1144(a)." 12 F.3d at 420. Proceeding on this assumption as to the scope of *Pilot Life*, we reasoned that *Pilot Life* directly controlled Custer's West Virginia action, which was filed against an insurance company for improper claims processing, and, without even engaging in the actual *Pilot Life* analysis, held that Custer's state action was not saved from preemption.*

---

* We also concluded in *Custer* that the case was controlled by our decision in *Powell v. Chesapeake & Potomac Telephone Co. of Virginia*, 780 F.2d 419, 423 (4th Cir. 1985), *cert. denied*, 476 U.S. 1170 (1986). In *Powell*, we addressed a beneficiary's state law claims against her former employer and the insurance company that administered the employer's uninsured ERISA plan for maladministration of her benefits claims. We held that each of Powell's state law claims related to the employer's ERISA plan, and were therefore pre-empted. In a passage relied on by the majority for the proposition that improper claims processing actions are pre-empted, *ante* at 9-10, we rejected Powell's

(Continued on next page)

Now, relying on *Custer's* assumption that the *Pilot Life* holding extended to all state law improper claims processing actions, and again largely ignoring the three-step saving clause analysis employed by the Court in *Pilot Life*, the majority summarily concludes in this case that *Custer* requires a holding that Tri-State's improper claims processing action is not saved from preemption.

In my view, the Supreme Court did not hold in *Pilot Life* that all state actions for improper claims processing fall outside the saving clause. The only question before the Court in *Pilot Life* was whether a claim by a *beneficiary* or a *participant* under a *state common-law doctrine of bad faith* (indeed, only Mississippi's law) was saved from preemption. In deciding that it was not, the Supreme Court neither addressed state improper claims processing actions by parties other than beneficiaries and participants or different actions brought under other state laws.

In *Custer*, our mistake was immaterial because the *beneficiary's* cause of action there in question was one specifically identified by the Court in *Pilot Life* as governed exclusively by

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(Continued)

argument that her claim against Connecticut General, the plan's administrator, was saved from pre-emption because it was brought under a state law that regulated insurance. *Id.* at 423-24. Although Connecticut General is, in fact, an insurance company, we held that, in its capacity as administrator, it was not all engaged in the "business of insurance" but rather served purely administrative functions, and therefore that the state law, as applied to Connecticut General, did not constitute a state regulation of insurance that was saved from pre-emption. *Id.*

Our holding in *Powell* turned, therefore, on the fact that Connecticut General was not engaged in the business of insurance, rather than on the fact that Powell's action was for improper claims processing. That an insurance company that administers but does not insure an ERISA plan is not engaged in the business of insurance for purposes of the saving clause hardly bears on this case, since Nationwide, which provided Tri-State with stop-loss insurance, obviously was engaged in the business of insurance.

ERISA. 481 U.S. at 56. Thus, our holding that Custer's cause of action was preempted was correct notwithstanding our misapprehension of the contours of the *Pilot Life* holding and our attendant failure to engage in the full inquiry undertaken by the Court in *Pilot Life*. Here, however, the majority is not saved by happenstance.

Unlike in *Pilot Life*, a "common-sense understanding" of the statutory text, 481 U.S. at 50, does support the argument that the West Virginia law before us "regulates insurance." If any law can be said to be "specifically directed toward th[e insurance] industry," *id.*, it is this statute, which, by terms, was enacted to, and does, "regulate trade practices in the business of insurance . . . ." W. Va. Code § 33-11-1.

Also here, unlike in *Pilot Life*, the West Virginia statute as applied to Tri-State's action (and, in my view, to the action in *Custer*) regulates "the business of insurance" under the McCarran-Ferguson Act. 15 U.S.C. § 1012. Tri-State alleges that Nationwide violated the West Virginia insurance code by deliberately and fraudulently delaying its charging of benefit claims against Tri-Sate's account in order to avoid coverage for those claims under its stop-loss policy with Tri-State. *See* Appellant's Br. at 5. Applying the West Virginia statute to regulate the determination of which claims are covered under Tri-State's stop-loss insurance policy with Nationwide certainly affects an "integral part of the policy relationship between the insurer and the insured," *Pilot Life*, 481 U.S. at 48-49 (quoting *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129 (1982)), since it certainly would "define the terms of the relationship between the insurer and the insured," *Pilot Life*, 481 U.S. at 51. It also would, by regulating when and how liability on benefit claims would be transferred from Tri-State to Nationwide, directly involve, if not actually "effect[,] a spreading of [Tri-State's] risk." *Id.* at 50. And, as noted above, the statute by terms is

"specifically directed toward [the insurance] industry." *Id.* Tri-State's action plainly does, therefore, regulate "the business of insurance" in accordance with the McCarran-Ferguson Act. *See United States Dept. of Treasury v. Fabe*, 113 S. Ct. 2202, 2209 (1993) ("There can be no doubt that the actual performance of an insurance contract falls within 'the business of insurance' [for purposes of McCarran-Ferguson Act] . . . ."); *SEC v. National Securities, Inc.*, 393 U.S. 453, 460 (1969) ("The relationship between the insurance company and the insured, the type of policy which could be issued, its *reliability, interpretation and enforcement*—these were the core of the 'business of insurance' [that Congress addressed in the McCarran-Ferguson Act]." (Emphasis added)).

Finally, and most importantly, Tri-State's state action does not, as the state actions in both *Custer* and *Pilot Life* did, run afoul of "the legislative intent concerning the [exclusivity of the] civil enforcement provisions provided by ERISA § 502(a), 29 U.S.C. § 1132(a)." *Pilot Life*, 481 U.S. at 52. While it is plain that the remedies provided in section 502(a) to *beneficiaries* and *participants* were intended to be exclusive, and therefore preempt state actions such as those in *Pilot Life* and *Custer*, it is equally plain that that section does not expressly provide any remedy to employers such as Tri-State, let alone one that Congress clearly intended to be exclusive.

In sum, I believe that we misassessed the reach of the *Pilot Life* holding in *Custer* and therefore failed to engage in the full *Pilot Life* analysis. We ultimately reached the correct conclusion in *Custer*, but for reasons that we never considered. However, for the same reasons that we did not consider in *Custer*, we, as a court, are incorrect here.

Because, in my view, Tri-State's state cause of action alleging that Nationwide fraudulently processed claims to avoid coverage on those claims is, under *Pilot Life*, saved from preemption, I cannot join the majority's opinion holding otherwise.

I also disagree with the majority's alternative holding that, because the ERISA plan here was essentially self-funded, the deemer clause applies to preempt Tri-State's claims. *Ante* at 10-11. The deemer clause, by its terms, only applies to "employee benefit plan[s]" and "trust[s] established under such []plan[s]," 29 U.S.C. § 1144(b)(2)(B). It does not speak at all to insurance companies such as Nationwide or claims against them. "By forbidding States to deem *employee benefit plans* 'to be an insurance company or other insurer . . . or to be engaged in the business of insurance,' the deemer clause relieves *plans* from state laws 'purporting to regulate insurance.'" *FMC Corp. v. Holliday*, 498 U.S. 52, 61 (1990) (emphasis added). Nationwide obviously is not an "employee benefit plan," and the deemer clause has no application to Tri-State's claims against it. *Powell v. Chesapeake & Potomac Telephone Co. of Virginia*, 780 F.2d 419, 423 (4th Cir. 1985), *cert. denied*, 476 U.S. 1170 (1986) ("Since Connecticut General [Life Insurance Company] is not an 'employee benefit plan,' the deemer clause is inapplicable to it."); *see FMC Corp.*, 498 U.S. at 61 ("An insurance company that insures a plan remains an insurer for purposes of state laws 'purporting to regulate insurance' after application of the deemer clause."). Thus, the district court's holding that the deemer clause preempts Tri-State's claims is, I believe, incorrect. Accordingly, I dissent from the majority's affirmance of that holding as well.

CERTIFICATE OF SERVICE

I hereby certify that, in accordance with Rule 29 of the Rules of the Supreme Court of the United States, three true and correct copies of the within Petition were sent on November 28, 1994 by first class mail, postage pre-paid, to all of the parties required to be served as follows:

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SUPREME COURT, U.S.
FILED
JAN 30 1995
OFFICE OF THE CLERK

No. 94-972

In The

Supreme Court of the United States

October Term, 1994

TRI-STATE MACHINE, INC.,

Petitioner,

vs.

NATIONWIDE LIFE INSURANCE COMPANY,

Respondent.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Fourth Circuit

BRIEF IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI

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BEST AVAILABLE COPY

QUESTIONS PRESENTED

1. Whether claims brought by a plan sponsor against a plan fiduciary for misadministration, breach of duty, and unfair trade practices, all of which directly implicate the administration of claims for benefits under an employee welfare benefit plan which is governed by ERISA, "relate to" the subject plan and are therefore preempted by ERISA.

2. Whether claims brought by a plan sponsor against a plan fiduciary for misadministration, breach of duty, and unfair trade practices, all of which directly implicate the administration of claims for benefits under an employee welfare benefit plan governed by ERISA, are saved from preemption pursuant to ERISA's "savings clause."

3. Whether, in a case in which a plan sponsor alleges misadministration of benefit claims, breach of duty relating to claims administration and unfair trade practices relating to claims administration, special or important reasons exist to overturn the application of the accepted ERISA preemption analysis in favor of giving an ERISA party state law remedies not allowed under ERISA.

LIST OF PARTIES AND RULE 29.1 LIST OF AFFILIATES

Nationwide Life Insurance Company is a wholly owned subsidiary of Nationwide Corporation. Nationwide Corporation is owned by Nationwide Mutual Insurance Company (95.3%) and Nationwide Mutual Insurance Company (4.7%), both of which are mutual insurance companies.

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STATUTES WHICH THE CASE INVOLVES

Article 11, Chapter 33, West Virginia Code, in pertinent part herein, reads as follows:

§ 33-11-2. Definitions.

As used in this article:

(a) "Person" includes any individual, company, insurer, association, organization, society, reciprocal, business trust, corporation, or any other legal entity, including agents and brokers. "Person" also includes hospital service corporation, medical service corporations and dental service corporations as defined in article twenty-four [§ 33-24-1 *et seq.*] of this chapter, and health care corporations as defined in article twenty-five [§ 33-25-1 *et seq.*] of this chapter. For purposes of this article hospital service corporations, medical service corporations, dental service corporations, and health care corporations shall be deemed to be in the business of insurance.

(b) "Commissioner" means the insurance commissioner of West Virginia.

(c) "Insurance policy" or "insurance contract" means the contract effecting insurance, or the certificate thereof, by whatever name called, and includes all clauses, riders, endorsements and papers attached thereto and a part thereof. (1957, c. 94; 1974, c. 51).

§ 33-11-3. Unfair methods of competition and unfair or deceptive acts or practices prohibited.

No person shall engage in this State in any trade practice which is defined in this article as, or determined pursuant to section seven [§ 33-11-7] of this article to be, an unfair method of competition or an unfair or deceptive

act or practice in the business of insurance. (1957, c. 97; 1974, c. 51).

§ 33-11-4. Unfair methods of competition and unfair or deceptive acts or practices defined.

The following are hereby defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:

* * *

(3) Defamation. No person shall make, publish, disseminate or circulate, directly or indirectly, or aid, abet or encourage the making, publishing, disseminating or circulating of any oral or written statement or any pamphlet, circular, article or literature which is false, or maliciously critical of or derogatory to the financial condition of any person and which is calculated to injure such person.

* * *

(5) False statements and entries. (a) No person shall knowingly file with any supervisory or other public official, or knowingly make, publish, disseminate, circulate or deliver to any person, or place before the public, or knowingly cause directly or indirectly, to be made, published, disseminated, circulated, delivered to any person or placed before the public, any false material statement of fact as to the financial condition of a person.

(b) No person shall knowingly make any false entry of a material fact in any book, report or statement of any person or knowingly omit to make a true entry of any material fact pertaining to the business of such person in any book, report or statement of such person.

§ 33-11-5. Favored agent or insurer; coercion of debtors.

(a) No person may:

(1) Require, as a condition precedent to the lending of money or extension of credit, or any renewal thereof, that the person to whom such money or credit is extended or whose obligation the creditor is to acquire or finance, negotiate any policy or contract of insurance through a particular insurer or group of insurers or agent or broker or group of agents or brokers;

(2) Unreasonably disapprove the insurance policy provided by a borrower for the protection of the property securing the credit or lien;

(3) Require directly or indirectly that any borrower, mortgagor, purchaser, insurer, broker, or agent pay a separate charge, in connection with the handling of any insurance policy required as security for a loan on real estate, or pay a separate charge to substitute the insurance policy of one insurer for that of another; or

(4) Use or disclose information resulting from a requirement that a borrower, mortgagor or purchaser furnish insurance of any kind on real property being conveyed or used as collateral security to a loan, when such information is to the advantage of the mortgagee, vendor, or lender, or is to the detriment of the borrower, mortgagor, purchaser, insurer, or the agent or broker complying with such a requirement.

* * *

(b)(4) For purposes of this section, "person" includes any individual, corporation, association, partnership, or other legal entity. (1957, c. 97; 1974, c. 51)

STATEMENT OF THE CASE

The Factual Background

Pursuant to Supreme Court Rule 15.1, and in fairness to the parties, it is necessary to briefly examine a number of factual inaccuracies asserted by Petitioner Tri-State Machine Company, Inc. ("Tri-State") to this Court in its Petition for Writ of Certiorari ("Petition") as well as examine the true nature of the relationship the parties shared.

The arrangement entered into by Respondent Nationwide Life Insurance Company ("Nationwide") and Tri-State is what is commonly called a minimum premium plan. The minimum premium plan was an alternative funding arrangement to traditional insurance which lowered Tri-State's insurance costs versus traditional insurance. The arrangement meant that Nationwide would provide administration of health, life, prescription drug, dental and disability insurance claims submitted by participants, dependents and beneficiaries of the employee welfare benefit plan established by Tri-State for its employees.

The documents which created the relationship between Nationwide and Tri-State were the contract of insurance and a Funding Agreement. The two documents, taken together, provided that Nationwide would determine the validity of claims submitted for payment under the plan. Validity was determined in accordance with the policy of insurance issued by Nationwide. Nationwide would decide whether a claim was payable and, if so, the amount that was payable. Whether a claimant was eligible to receive benefits under the plan was based upon Tri-State's decision, as plan sponsor, which classes of employees were to receive certain levels of benefits. Moreover, the information Nationwide had with

regard to eligibility was provided to Nationwide at least monthly by Tri-State.

Nationwide hired a third-party administrator to adjudicate claims in accordance with written plan terms. The decision to seek the services of a third-party administrator in such a relationship is not unusual. Upon the claims decision, Nationwide paid claims out of its own funds. Monthly, Nationwide would compile and send to Tri-State a summary of charges (the claims) paid by Nationwide and would also send a premium billing statement showing amounts due for each participant, dependent and beneficiary enrolled in the plan. The summary of charges and the premium billing statement together comprised the amount Tri-State owed to Nationwide for the prior month. These amounts together is what Tri-State generically refers to in its Petition as "premium." Tri-State's liability was limited to its monthly and yearly aggregate stop-loss amounts.

Tri-State sponsored and funded the employee welfare benefit plan, and retained the discretion to determine how the plan was funded, the kinds of coverage that would be available to its employees, who would be covered, at what levels they would be covered and the ability to alter coverage.

Consistent with this arrangement, Nationwide undertook to process hundreds of claims for benefits submitted by the plan participants of the Tri-State employee welfare benefit plan between July 1, 1987 and July 1, 1989. The relationship continued until July, 1989 when Nationwide terminated the agreement pursuant to the termination provisions contained in the contract.

The contract of insurance and the Funding Agreement necessarily have to be read in conjunction to determine and understand the rights and liabilities the parties

shared during the time the agreement was in force. In order to determine the amounts that would be due from Tri-State to Nationwide for premium and claims liability up to the stop-loss amount, and determine whether Tri-State or Nationwide had honored their mutual obligations under the plan, the policy of insurance and the Funding Agreement would have to be read together.

Because Tri-State has chosen in this litigation to wage its fight against Nationwide through pleadings and motions only, the merits of the instant case have never been brought before a trier of fact. As such, a number of "facts" alleged by Tri-State in its Petition to this Court are nothing more than baseless, unsupported attacks. So that the Court is not misled into accepting as fact the unfounded allegations made by Tri-State, Nationwide points out a number of inaccuracies asserted by Tri-State in the Petition.

It is not true, as Tri-State asserts at page 6 of its Petition, that Nationwide in any way acted dishonestly toward Tri-State or to the plan. Nor did Nationwide, at any time, manipulate posting dates of claims for any reason. Further, Nationwide never intentionally reported claims to Tri-State later than they were actually paid. At all times, Nationwide acted in the best interests of Tri-State and consistently with its express obligations under the agreement in administering Tri-State's employee welfare benefit plan.

Additionally, it is not true that what Tri-State seeks is a remedy for fraud in the sale of insurance and fraud in the computation of premiums as asserted at various times in its Petition. From the first instance of filing the litigation below, Tri-State alleged that Nationwide had administered claims under the plan incorrectly, that Nationwide had breached its fiduciary duty to Tri-State

under the plan, and that, as a result, Tri-State and the plan suffered damages. (See, e.g. Complaint, App. 1a-10a; Statement of Facts in Plaintiff's Memorandum of Law in Support of Motion to Remand, App.15a-16a). Only since appealing the district court's judgment to the Fourth Circuit Court of Appeals, and now to this Court, has Tri-State attempted to characterize this case as one for fraud in the sale of insurance or fraud in the computation of insurance premium. The pleadings and motions filed by Tri-State in the litigation below allege misadministration of claims submitted to the plan by plan participants and beneficiaries, allegedly resulting in miscalculated premiums which were charged to Tri-State.

The Case Below

On February 26, 1990, Tri-State filed a five-count complaint against Nationwide in the Circuit Court of Ohio County, West Virginia. The complaint alleges that Nationwide negligently and purposefully mismanaged the administration of an employee benefit plan which was created by Tri-State to provide health and accident benefits for its employees. Nationwide timely removed the case to the United States District Court for the Northern District of West Virginia, based on diversity jurisdiction and federal question jurisdiction under ERISA.

One of the affirmative defenses asserted by Nationwide was that this action was wholly preempted by ERISA. On April 23, 1991, Tri-State submitted its Motion For Partial Summary Judgment which sought a finding that its complaint was not preempted by ERISA. On September 23, 1991, the district court issued its Memorandum Opinion and Order which found that Tri-State's

complaint " . . . clearly relates to an employee welfare benefit plan," and was therefore preempted by ERISA. Tri-State sought reconsideration of this order, or, alternatively, certification for an interlocutory appeal.

The district court denied Tri-State's request for reconsideration of summary judgment, but certified the ERISA preemption issue for an interlocutory appeal under 28 U.S.C. § 1292(b). Tri-State submitted a Petition For Permission To Appeal to the Fourth Circuit Court but this petition was denied on March 26, 1992.

On April 6, 1992, Tri-State submitted its Motion to Vacate and Reenter Order. This motion sought permission from the district court for another interlocutory appeal on the issue of ERISA preemption. The district court denied this motion, and "ORDERED that the plaintiff inform the Court within thirty (30) days of entry of this Order whether it intends to pursue this action under ERISA." Tri-State submitted a Notice on July 8, 1992, which informed the court that "plaintiff intends to pursue this action under ERISA."

Nine months after submitting its notice of intent to proceed under ERISA, Tri-State filed a Motion To Amend the Complaint, which yet again sought to escape ERISA preemption. This motion sought to change two factual allegations made three years earlier by Tri-State upon which the district court relied in holding that ERISA preempted this action. Filed simultaneously with its Motion To Amend was Tri-State's Conditional Motion For Entry of Final Summary Judgment And Request For Entry of Final Judgment. This last motion sought final judgment on the ERISA preemption issue so as to allow an immediate appeal. In the alternative, the motion sought, for a third time, summary judgment that Tri-State's complaint was not preempted by ERISA. On July

2, 1993, the district court entered the order which held again that ERISA wholly preempted Tri-State's state law causes of action. The court stated:

> In that this issue has been repeatedly and exhaustively briefed, in that Tri-State has fully defended and has presented all material pertinent to its claim, and since Tri-State has failed to seek leave to amend its complaint to assert an ERISA claim, the court hereby GRANTS summary judgment *sua sponte* for Nationwide, and hereby DISMISSES this action.

From this order, Tri-State appealed to the Fourth Circuit Court of Appeals.

The issues raised by Tri-State were briefed, and the Fourth Circuit Court heard oral argument on March 9, 1994. The court affirmed the decision of the district court on August 31, 1994, specifically finding that Tri-State's common and statutory law claims related to the subject employee welfare plan and were not saved from preemption. Noting its decision in *Custer v. Pan American Life Ins. Co.*, 12 F.3d 410 (4th Cir. 1993) (applying *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987)), and the decision in *Ball v. Life Planning Services, Inc.*, 187 W.Va. 682, 421 S.E.2d 223 (1992), the court concluded that the West Virginia Unfair Trade Practices Act was likewise not saved from preemption.

Upon further reviewing the procedural history of the case, the appeals court had no problem finding that the district court did not abuse its discretion in " . . . bringing this tortured pleading battle to an end." *Tri-State Machine Co., Inc. v. Nationwide Life Ins. Co.*, 33 F.3d at 315.

SUMMARY OF THE ARGUMENT

Nationwide respectfully requests that this honorable Court deny Tri-State's Petition for a Writ of Certiorari seeking review of the decision of the Fourth Circuit Court of Appeals in this case since no error was committed by the courts below in deciding that Tri-State's claims were preempted by ERISA and since there are no issues raised by Tri-State that warrant review by this Court.

Tri-State's argument in support of its Petition to the Court apparently is that it has been deprived, because of congressionally mandated federal preemption of ERISA claims, the choice of state law remedies it would *prefer* to have against Nationwide to compensate Tri-State for its perceived injury. There is not any serious question that Tri-State had the ability, at the time it initiated this litigation and since, to seek redress under ERISA to correct perceived wrongs within the relationship Tri-State and Nationwide shared, although Tri-State argues to the contrary. Tri-State is most concerned that the supremacy of federal law over state law prevents it from seeking the state common law and statutory remedies it believes should be available to it to pursue against Nationwide despite the federal nature of the claims.

Consequently, Tri-State concocts a weak and obtuse argument about the lack of available remedies and the lack of a forum when it has been clear since the inception of this litigation that Tri-State had the ability to pursue the express relief provided under ERISA's civil enforcement provisions, ERISA § 502, or under the emerging federal common law the courts have developed under ERISA. This fact is evident enough that Tri-State cites to precedent for federal common law relief afforded for ERISA violations. (See e.g., p. 16 of Tri-State's Petition).

Tri-State asks this Court to accept this case and redefine the parameters of federal preemption of ERISA claims absent congressional mandate. The posture assumed by Tri-State is that even though this Court and the circuit courts of appeal adhere to the established principles of ERISA preemption in accordance with the letter and spirit of ERISA, the Court should now obliterate those principles in favor of an idea that requires preemption of claims made by ERISA plan participants against a plan fiduciary, but not of claims made by plan sponsors or plan fiduciaries against a plan fiduciary, in cases where the claims are indistinguishable.

Congress, in enacting ERISA, could not have envisioned such an arbitrary distinction. This is acutely apparent when one considers the sweeping scope of ERISA's preemption provisions. To have the relief Tri-State suggests ought to be afforded it in this case would require action by Congress, not action by this Court.

Moreover, there is not a conflict in the circuits, as suggested by Tri-State, with regard to applying the "relates to" test for preemption or with regard to applying the "savings clause." Cases decided by this Court and the circuit courts of appeal consistently apply the law of preemption and adhere to its tenets.

Under the sound and consistently applied law of ERISA preemption, as it has been articulated and applied by this Court and the circuit courts of appeal, Tri-State's claims against Nationwide "relate to" the subject employee welfare benefit plan and are therefore preempted by ERISA. Moreover, Tri-State's allegations of breach of contract, breach of implied covenants of good faith and fair dealing, bad faith, and violation of the West Virginia Unfair Trade Practices Act are laws of general application and do not regulate the business of insurance.

Consequently, Tri-State's claims are not "saved" from preemption.

ARGUMENT

I. THE CLAIMS MADE BY TRI-STATE IN THIS LITIGATION RELATE TO THE SUBJECT EMPLOYEE WELFARE BENEFIT PLAN, ARE PREEMPTED BY ERISA AND ARE NOT SAVED FROM PREEMPTION

Throughout its Petition, Tri-State asserts that it alleged fraud in the sale of insurance and that the courts below determined those claims were preempted. In this manner, Tri-State attempts to disguise the issues it actually raised in the district and appeals courts. Tri-State suggests to this Court that its pleas to the lower courts to address the issues of fraud in the *sale* and in *computation of premium* have been ignored, when the nature of the claims brought by Tri-State and the relief it has sought all along in its pleadings and motions necessarily involve construction of the subject plan terms to decide whether the plan was administered properly or whether Tri-State was correctly charged for the benefit it sought in its relationship with Nationwide. Tri-State's argument that its claims were ignored by the courts below is disingenuous.

It is not disputed that the subject plan is an employee welfare benefit plan governed by ERISA. Nor, can it be seriously disputed that the claims asserted by Tri-State against Nationwide "relate to" the plan in that the claims implicate plan administration and Nationwide's duties to Tri-State and the plan under express plan terms. Consequently, Tri-State's state common law and statutory law claims are preempted by ERISA. Moreover, those claims are not saved from preemption under ERISA § 514, 29

U.S.C. § 1144 since the state laws involved apply generally to, and do not regulate, the business of insurance.

A. Tri-State's Claims Clearly "Relate To" The Subject Employee Welfare Benefit Plan

In the Complaint it filed on February 26, 1990, Tri-State alleged a series of claims which it asserted had caused damage to Tri-State, the Tri-State employee welfare benefit plan and the participants and beneficiaries of the plan. The factual allegations and claims Tri-State raised in the Complaint include: Nationwide's duty to administer the plan (para. 11, App. 2a); the calculation of Tri-State's liabilities under the contract on the basis of claims paid (para. 16, App. 3a); Nationwide's failure to timely process claims under the subject employee benefit plan (para. 17, App. 3a); Nationwide's fiduciary duty to Tri-State pursuant to the plan and breach of that duty (paras. 20, 30 App. 4a, 6a); Nationwide's failure to administer the plan in accordance with plan terms (para. 21, App. 4a); Nationwide's payment of claims to the wrong medical providers, erroneously issuing coverage cards, erroneously charging claims, improperly paying and denying claims and delaying processing claims (para. 22, App. 4a-5a); incorrectly calculating Tri-State's liabilities and premiums under the plan (paras. 23, 26, 27, App. 5a); the financial detriment caused to Tri-State and its plan's participants as the result of Nationwide's alleged failure to perform its duties under the plan (paras. 31, 32, 35, App. 6a); and Nationwide's consequential breach of its obligations to Tri-State under the plan (paras. 42, 44, App. 7a, 8a).

These claims were raised and at issue before the district court. Moreover, Tri-State reaffirmed these as its core allegations when it sought remand of the case to

state court. (See Statement of Facts, in Plaintiff's Memorandum of Law in Support of Motion to Remand, App. 15a-16a).

The expansive sweep of ERISA's preemption provision is practically axiomatic. When it enacted ERISA, Congress intended to preempt the field of employee benefit regulation completely, and provided that all state laws which relate to an ERISA plan are superseded by federal law.

In 1974, Congress enacted ERISA, which reserves to federal law the entire task of regulating employee benefit plans. ERISA's most sweeping safeguard, which secures the rights and expectations of the entities protected by ERISA, is the supercedure provision at 29 U.S.C. Section 1144(a).

The expansiveness of preemption has been articulated and affirmed time and again by this Court and the other federal courts. The scope of ERISA preemption is characterized in *Ingersoll-Rand v. McClendon*, 498 U.S. 133, 111 S.Ct. 478, 112 L.Ed.2d 474 (1990), wherein the Court, in reviewing Congress' intent in drafting ERISA's preemption provision, stated:

> "The pre-emption clause is conspicuous for its breadth." . . . Its "deliberately expansive" language was "designed to 'establish pension plan regulation as exclusively a federal concern.' " . . . The key to § 514(a) is found in the words "relate to." Congress used those words in their broad sense, rejecting more limited pre-emption language that would have made the clause "applicable only to state laws relating to the specific subjects covered by ERISA." . . . Moreover, to underscore its intent that

> § 514(a) be expansively applied, Congress used equally broad language in defining the "State law" that would be pre-empted. Such laws include "all laws, decisions, rules, regulations, or other State action having the effect of law." § 514(c)(1), 29 U.S.C. § 1144(c)(1). [citations omitted]

498 U.S. at 138, 111 S.Ct. at 482-483, 112 L.Ed.2d at 479.

In *Ingersoll-Rand*, the unanimous Court addressed the question of determining whether a state court cause of action "relates to" an ERISA plan. The Court expressed a rather uncomplicated standard for that determination: if the existence of an ERISA plan is a critical factor in establishing liability, then the action most assuredly relates to an ERISA plan. *Ingersoll-Rand*, 498 U.S. at 140, 111 S.Ct. at 483, 112 L.Ed.2d at 479. Where a court's inquiry "must be directed to the plan," the cause of action relates to an ERISA plan and is preempted. *Id.*

Tri-State's Complaint unequivocally relates to an ERISA plan. Every allegation asserted in the complaint directly implicates the administration and operation of Tri-State's employee welfare benefit plan. The allegations of misadministration of claims, breach of duty relating to claims handling and damages occasioned thereby relate to the plan. The existence of an ERISA plan and construction of its express terms are critical factors in determining whether liability exists. A court's inquiry must be directed to the plan, and therefore Tri-State's state law actions relate to the ERISA plan. The evaluation used by the Court in *Ingersoll-Rand* illustrates Tri-State's allegations are preempted by 29 U.S.C. § 1144(a).

B. The State Law Claims Asserted By Tri-State Are Not Saved From Preemption

The West Virginia Supreme Court has determined that Chapter 33-11-1 *et seq.* is preempted by ERISA, and not saved by the savings clause. In *Ball v. Life Planning Services, Inc.*, 187 W.Va. 682, 421 S.E.2d 223 (1992), the court stated:

> [Plaintiff's claim under W.Va. Code § 33-11-4(9)] relates to unfair claim settlement practices and is clearly the same type of claim that the United States Supreme Court found to be preempted by § 514(a) of ERISA in *Pilot Life Insurance Co. v. Dedeaux*.

Id. at 227. The Supreme Court of West Virginia has made clear its position that its state's Unfair Trade Practices Act is preempted by ERISA. This is so despite the purpose enunciated by the West Virginia legislature in the preamble to West Virginia's unfair trade practices act which purports to purpose the Act to regulate the business of insurance.

Because of their general application, state laws which provide statutory causes of action against insurers for unfair practices do not generally regulate the business of insurance and are not saved from preemption by ERISA's savings clause. Alabama's statutory laws, which prohibit misrepresentation and deceptive practices of insurers are not saved and are preempted, as such statutes do not regulate insurance. *Farlow v. Union Central Life Ins. Co.*, 874 F.2d 791 (11th Cir. 1989); also see *Swerhun v. Guardian Life Ins. Co. of America*, 979 F.2d 195 (11th Cir. 1992) (Florida insurance deceptive trade practices statutes preempted by ERISA). State statutory laws of Texas under the Deceptive Practices Act and Insurance Code are preempted by ERISA. *Hogan v. Kraft Foods*, 969 F.2d 142 (5th Cir. 1992); also see, *Moore v. Provident Life & Accident Ins.*

Co., 786 F.2d 922 (9th Cir. 1986) (California unfair claims settlement statute preempted by ERISA); *International Resources v. New York Life Ins.*, 950 F.2d 294 (6th Cir. 1991) (Kentucky unfair and deceptive practices statutes preempted by ERISA).

In *Powell v. Chesapeake & Potomac Telephone Co.*, 780 F.2d 419 (4th Cir. 1985), *cert. denied*, 476 U.S. 1170, the court held that the Virginia Unfair Trade Practices Act, portions of which dealt specifically with misrepresentation by insurance companies, was preempted by ERISA, and was not saved by the savings clause. The court in *Powell* found that the Virginia statutes did not regulate insurance as specified in Section 1144. Also see, *Keel v. Group Hospitalization Medical Services, Inc.*, 695 F.Supp. 223 (E.D. Va. 1988).

Similarly, West Virginia's unfair trade practices act applies generally to insurers and other persons and does not only regulate the business of insurance. For example, § 33-11-3 provides that "no person" shall engage in an unfair method of competition. § 33-11-4 prohibits "any person" from defaming another and making false statements and entries regarding another's financial condition. Other provisions of the West Virginia statute likewise have application generally to both those within and those outside the business of insurance. Clearly, the West Virginia unfair trade practices statute does not regulate the business of insurance.

The remaining claims asserted by Tri-State in the instant case, those brought under West Virginia common law, are not saved from preemption by ERISA since those claims apply generally to all types of actions which may be brought in that state. Thus, Tri-State's common law claims of breach of contract, breach of implied covenants of good faith and fair dealing, bad faith and breach of

duty are not saved from preemption under ERISA. See *Pilot Life Ins. Co v. Dedeaux*, 481 U.S. 41, 107 S.Ct. 1549, 95 L.Ed.2d 39 (1987).

C. The Deemer Clause Is Inapplicable To This Case

This Court need not reach the issue of when an employee welfare benefit plan is self-funded and when it is fully insured for any purpose, including the purpose of deciding whether the "deemer clause," 29 U.S.C. § 1144 (b)(2)(B), applies to this case. The "deemer" argument has unnecessarily been brought into this case because the state law which Tri-state alleges has been violated is not saved from preemption. Tri-State's deemer argument is premised upon whether the plan at issue is self-funded or fully insured. The Fourth Circuit in this case, and other circuits, have determined that a self-funded plan does not lose its character upon the purchase of stop-loss insurance alone. Here, Tri-State has not sought to demonstrate whether its plan was self-funded or fully insured prior to entering into the relationship with Nationwide. Without this showing, Tri-State cannot avail itself of an argument that the courts below have incorrectly concluded the Tri-State plan is self-funded.

Moreover, it is clear from Tri-State's Petition that it misapprehends the preemption analysis as applied to the deemer clause. At pages 27-28 of the Petition, Tri-State suggests that the Fourth Circuit court in the case below applied the deemer clause analysis " . . . to prevent the 'saving' of any state law causes of action." This is a clear misstatement of the lower court's ruling and it reveals that Tri-State is unclear as to how the deemer clause was applied to the preemption analysis in this case. Both the district court and circuit court of appeals determined that

Tri-State's state law claims were not saved from preemption. The courts did not need to explore the application of the deemer clause to "prevent the 'saving' " of the causes of action asserted. Once the courts determined that the laws in question were not saved, no further preemption analysis was required. As the Fourth Circuit court points out in its opinion, the district court recognized that the deemer clause could be an alternative basis to find that Tri-State's state law claims were preempted. The circuit court of appeals found no reason to disturb the district court's conclusion, and doing so would have no impact on the conclusions reached in the instant case.

II. THERE IS NO CONFLICT IN THE CIRCUITS OVER THE APPLICATION OF THE "RELATES TO" DOCTRINE OR THE "SAVINGS CLAUSE"

The cases Tri-State cites, claiming conflict over the application of the preemption analysis, deal with issues and facts as diverse as their number. A review of the cases cited by Tri-State shows that the circuits are not in conflict over the application of the "relates to" test and the application of the "savings clause"; rather, in reviewing those cases, it is readily apparent how consistently the courts have applied and continue to apply the law of preemption in ERISA cases.

Tri-State would ask this Court to disregard mandated federal preemption of ERISA claims on the basis that the cases which apply the "relates to" test and the "savings clause" are inconsistently applied. But Tri-State's prayer is offered in a case where the claims it brought before the courts below directly implicate the administration of a plan governed by ERISA and where the law is not saved

from preemption. Tri-State attempts to disguise its claims so as to make its plea more appealing.

A. The Circuit Courts Are Not In Conflict Over When A Claim "Relates To" A Plan

Tri-State cites *Consolidated Beef Indus. v. New York Life Ins. Co.*, 949 F.2d 960 (8th Cir. 1991), *cert. denied*, 112 S.Ct. 1670 (1992) at page 17 of its Petition. In that case the court, noting that the Plaintiff's claims were for improper plan administration, recognized the broad preemption provision contained in ERISA and that state law claims for improper plan processing are preempted. *Id.* at 963. The court further recognized that since ERISA allows equitable relief against both fiduciaries and non-fiduciaries, Congress intended preemption to apply even where no ERISA remedy existed. 949 F.2d at 964.

In *First National Life Ins. Co. v. Sunshine-Jr. Food Stores, Inc.*, 960 F.2d 1546 (11th Cir. 1992), *cert. denied*, 113 S.Ct. 1045 (1993), cited by Tri-State at page 16 of its Petition, the court rejected plaintiff's argument that its claims of mishandling benefit payments and failure to adhere to terms of the group policy which was part of the subject employee welfare benefit plan did not "relate to" the plan. Quoting *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, 97, 103 S.Ct. 2890,2900, the court stated: "Congress used the words 'relate to' in their broad sense and did not mean to preempt only state laws specifically designed to affect employee benefit plans. . . . A state law relates to an employee benefit plan if it 'has a connection with or reference to such a plan.' " *Id.* at 1550.

In *Farlow v. Union Cent. Life Ins. Co.*, 875 F.2d 791 (11th Cir. 1989), beneficiaries of an employee welfare benefit plan brought an action against the insurer and insurance agent alleging fraudulent misrepresentation,

negligence and violation of Alabama's twisting statute. On interlocutory appeal, the Eleventh Circuit stated that a state law cause of action "relates to" an employee benefit plan if the employer's conduct giving rise to such claim was not "wholly remote in content" from the benefit plan. *Id.* at 794, citing *Clark v. Coats & Clark, Inc.*, 865 F.2d 1237 (11th Cir. 1989).

In *Airparts Co., Inc. v. Custom Benefit Services of Austin, Inc.*, 28 F.3d 1062 (10th Cir. 1994), cited by Tri-State at pages 17 and 18 of its Petition, the court acknowledged that the ERISA preemption provision is "deliberately expansive." *Id.* at 1065. The court further stated that what triggers ERISA preemption is not just any indirect effect on administrative procedures but rather an effect on the primary administrative functions of benefit plans, such as determining an employee's eligibility for a benefit and the amount of that benefit. *Id.*

In *Perkins v. Time Ins. Co.*, 898 F.2d 470 (5th Cir. 1990), the insured brought an action against the employer's group health insurer and insurance agent for tortious breach of contract. On appeal, Perkins sought to shift the focus of his complaint to Mississippi statutes regulating the sale and solicitation of insurance. In analyzing Perkins' claims against the insurer, the court determined that they related to an employee benefit plan and must fall within the scope of ERISA's preemption clause. The court noted that Perkins' complaint, which alleged tortious breach of contract as its sole cause of action, clearly mirrors that which *Pilot Life* has held to be preempted under ERISA. As to the claim for fraudulent inducement against the insurance agent, the court found that state law did not affect the relations among the *principal ERISA entities* (the employer, the plan fiduciaries, the plan, and

the beneficiaries), was only indirectly related to the plan and was not preempted by ERISA.

In *Aetna Life Ins. Co. v. Borges*, 869 F.2d 142 (2d Cir.), *cert. denied*, 493 U.S. 811 (1989), the court held that the Connecticut escheat law at issue was too tenuous, remote and peripheral to require preemption under Section 514(a). Because the Connecticut escheat law at issue applies to lost and abandoned property generally and does not focus on ERISA benefit plans, the court determined that the law was not preempted.

Like the court in *Perkins, supra*, the court in *Monarch Cement v. Lone Star Indus.*, 982 F.2d 1448 (10th Cir. 1992), found no preemption of a dispute between the buyer of a company and the seller over the allocation of responsibility for certain employee benefits under the contract of sale. The court found that the dispute was limited to assessing the relative responsibilities of the parties for payment and did not affect the administration of the plan or the relationship between the principal ERISA entities.

Those cases are wholly distinguishable from the case at bar, since the instant case directly involves the principal ERISA entities (plan sponsor and plan fiduciary) and since the administration of the subject plan is directly implicated.

Another case which Tri-State cites in support of its position that the circuits are in conflict over the application of the "relates to" test is *Martori Bros. Distributors v. James-Massengale*, 781 F.2d 1349 (9th Cir.), amended, 791 F.2d 799, *cert. denied*, 479 U.S. 949 (1986). In that case the California Agricultural Relations Board reviewed a question of unfair labor practice claims regarding alleged failure to bargain in good faith. In affirming a district court's grant of summary judgment for the Board, the

Ninth Circuit held that ERISA did not preempt the calculation of a make-whole award on the basis of fringe benefits. However, the court noted that the principal underlying decisions regarding preemption of state laws appears to be that " . . . the state law is preempted by Section 514(a) if the conduct sought to be regulated by the state law is 'part of the administration of an employee benefit plan'; that is, the state law is preempted if it regulates the matters regulated by ERISA: disclosure, funding, reporting, vesting and enforcement of benefit plans." *Id.* at 1357-58.

In *Rebaldo v. Cuomo*, 749 F.2d 133 (2d Cir. 1984), *cert. denied*, 472 U.S. 1008 (1985), an action by an employee benefit plan against the State of New York was brought challenging a statute which prohibited hospitals from establishing in-patient charges for self-insured employee benefit plans other than authorized by statute. The statute was enacted as a demonstration project to contain hospital costs under Medicaid and Medicare. Quoting *Shaw v. Delta Airlines*, 103 S.Ct. at 2901, the court determined that New York's decision to regulate the amounts a hospital can charge affected employee benefit plans in too tenuous, remote or peripheral manner to warrant a finding that the law relates to the plan. 749 F.2d at 138.

In *Whitworth Bros. Storage Co. v. Cent. States Pension Fund*, 794 F.2d 221 (6th Cir. 1986), *cert. denied*, 479 U.S. 1007 (1986), the court determined that federal common law actions were available to an employer who sued to recover payments to an employee retirement plan made in error. The scope of ERISA preemption is so broad as to displace state law causes of action for which ERISA does not provide a specific remedy.

In *Hermann Hospital v. MEBA Medical & Benefits Plan*, 845 F.2d 1286 (5th Cir. 1988), the court noted that ERISA

preempts all state law claims which relate to an employee benefit plan although limited exceptions to this broad preemption were also enacted. The court noted that the narrow issue in the case was whether the state common law causes of action for breach of fiduciary duty, negligence, equitable estoppel, breach of contract and fraud alleged by Hermann Hospital related to the MEBA plan, or whether they were too tenuous, remote and peripheral to the plan to be preempted.

Here, as in the other cases cited above, the test employed by the court dealt directly with the relationship of the claims to the employee benefit plan at issue.

It is important to recognize that the cases cited by Tri-State as being in conflict are quite different factually from each other and quite different factually from the instant case. A review of the underlying ERISA preemption principles contained in those cases shows they are not in conflict. The courts have consistently applied the law as it has been outlined by this Court. Consistently, the courts have held that if plan administration is implicated, if a claim has a connection to a plan and is not too remote or peripheral to a plan, and if the claims involve the principal ERISA entities, that claim relates to the plan under the broad sweep of ERISA preemption Congress designed.

B. The Circuits Are Not In Conflict Over The Application Of The "Savings Clause"

Tri-State lashes out at the circuit court of appeals in the case below claiming that it " . . . perfunctorily applied the McCarran-Ferguson test . . . and reached the conclusion that Congress intended to displace state law that would otherwise provide an employer with remedies against an insurance company from whom the employer

purchased insurance." (Petition at p. 23) Here again, Tri-State attempts to mask the true nature of the claims it asserted against Nationwide and does not reveal them in a true context. In a true context, the context of ERISA, this cause is not properly characterized as a conflict between an employer and an insurer; rather, the conflict is related to an employee welfare benefit plan and is a dispute between a plan sponsor and plan fiduciary over plan administration and duties associated with written, express plan terms.

Tri-State compares the determination reached by the district court and Fourth Circuit court in the instant litigation to a case decided on wholly different facts, *International Resources, Inc. v. New York Life Ins. Co.*, 950 F.2d 294 (6th Cir. 1992), *cert. denied*, 112 S.Ct. 2941 (1992), claiming that the two cases reveal a conflict between the circuits as to the application of the "savings clause." Nowhere is there any analysis or argument by Tri-State that would support the proposition that the savings clause is misapplied by the courts. Indeed, Tri-State does not attempt to show, in any way, how the case below and *International Resources* reveal a conflict on the application of the savings clause by the courts. The case below and *International Resources*, are so diverse factually that a comparison cannot be reasonably made. *International Resources* deals with a claimed injury arising out of a proposed cancellation of a group health policy of insurance. The instant case deals with the manner in which a plan of insurance governed by ERISA was administered. Both cases apply an analysis of the "savings clause." While the Fourth Circuit determined that Tri-State's claims were not saved from preemption on the guidance of *Pilot Life*, which the court correctly applied, the Sixth Circuit court looked to the guidance provided by *FMC Corp. v. Holliday*,

111 S.Ct. 403, (1990), and correctly applied the instruction provided by that case. As both *Pilot Life* and *FMC v. Holliday* soundly and consistently apply the preemption analysis, one cannot reasonably conclude that the instant case and *International Resources* signal a conflict among circuits on the application of the savings clause.

III. NO SPECIAL OR IMPORTANT REASONS EXIST FOR GRANTING THE PETITION FOR WRIT OF CERTIORARI

It must be reemphasized that Tri-State's case against Nationwide, as asserted by Tri-State in the courts below, has nothing to do with claimed irregularities in the sale of an insurance product. Tri-State complains that this case " . . . is immensely important because it affects the enforceability of every state's Unfair Trade Practices Act against insurance companies in the sale of insurance products." (Petition, p. 10) The case alleged by Tri-State against Nationwide deals strictly with claimed misadministration of and breach of duty under the specific terms of an employee welfare benefit plan Tri-State sponsored. Thus, whether this Court has had " . . . occasion to address the effect of ERISA on regulating the sale of insurance products by insurance companies to employers within the context of employer-sponsored benefit plans. . . . " (Petition, p. 10) is not germane to the issues raised by Tri-State in this litigation, as Tri-State has always maintained that the *administration* of the subject employee benefit plan was inappropriate, not the sale of insurance to the plan sponsor. The claims raised go to the very core of the administrative activity associated with the plan.

The purpose of ERISA preemption is to eliminate difficulty of coordinating administrative activities with respect to employee benefit plans which would occur if plans were subject to different regulations in different states. In enacting ERISA, Congress did not deny states the right to regulate insurers or insurance products; rather, it left unfettered the states' ability to regulate insurance practices. Congress, however, recognized the need to have an established and uniform law to apply to employee benefit plans so as to avoid subjecting plans to inconsistent enforcement schemes under the state laws of the several states. Thus, Congress provided for a broad sweep of laws that would subject employee benefit plans to regulation by the states which was not uniform in application when it enacted ERISA.

Since that time, this court and the circuit courts of appeal have enforced ERISA in accordance with the spirit intended by Congress. The courts have consistently recognized that Congress intended the civil enforcement provisions of ERISA to be the exclusive remedies and have applied the preemption doctrine with a regularity and soundness that promotes the congressional mandate imposed by ERISA. Where ERISA reveals a gap in remedies available, federal common law fills the gap.

Tri-State seeks to have the mandate of preemption obliterated in favor of allowing state law remedies to ERISA litigants in cases which inextricably involve plan administration and the construction of express plan terms in deciding parties' rights under a plan. To allow this would require the Court to undertake a role that is within the sole province of Congress, that of making law. Congress' authority to supplant state law with federal law for the purpose of regulating employee benefits cannot be overridden by the courts, or defined in a manner that is

inconsistent with what Congress intended. Any attempt to redefine the principles and parameters of ERISA, including the parameters of preemption, must be left to Congress.

The Court should not accept this case for review if the effect of doing so would be to redefine ERISA preemption in a way that requires preemption of claims by plan participants against a plan fiduciary but does not require preemption of identical claims by a plan sponsor against a plan fiduciary. This is the course Tri-State proposes the Court follow. Indeed, what Tri-State proposes is to have this Court overturn more than a decade of carefully considered law interpreting and applying the mandates of ERISA to accommodate Tri-State in its quest to seek state law remedies in a case clearly governed by ERISA. What Tri-State proposes the Court do is upset the entire scheme of ERISA preemption in favor of the remedy *it* wants under state law in a case which clearly relates to an employee welfare benefit plan governed by ERISA.

Congress has the authority to redefine the scope and application of ERISA to disputes involving employee welfare benefit plans if it should so choose. Congress has determined that in the area of employee benefits, federal law would supersede the authority of the states to regulate disputes over employee benefit plan administration. To the extent that Congress left regulation of the *business* of insurance to the states, state law may be applied to resolve disputes. Thus Congress, not the courts, must have the say when, and how, ERISA should be redefined, to what it will apply and what exceptions will be carved out.

The role of the courts is to interpret and apply the law that is promulgated, not change it. Nationwide

respectfully submits that the courts have done this consistently and correctly with respect to ERISA preemption and that the instant case brings no issues before this Court which point out the need to examine, or reexamine, the decision reached in this case.

CONCLUSION

At issue is the effect of ERISA preemption upon claims made by a plan sponsor against a plan fiduciary regarding the alleged misadministration of claims made under the plan, breach of duty under the plan and damages occasioned as a result. Tri-State's state law claims relate to the plan and are preempted by ERISA's sweeping supersedure provisions. Further, Tri-State's claims are not saved from preemption.

The courts have consistently applied the ERISA preemption analysis in factually diverse cases and no conflict exists in the circuit courts which gives rise to a need to evaluate the application of ERISA preemption. The instant case is no exception in the way it has been treated by the courts below.

No special or important reasons exist for granting Tri-State's Petition. The issues relating to this case are settled and no special circumstances exist which raise reasons to revisit or redefine the law of ERISA preemption.

For all of the foregoing reasons, Nationwide respectfully submits that the Court should deny Tri-State's Petition.

Respectfully submitted,

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IN THE CIRCUIT COURT OF
OHIO COUNTY, WEST VIRGINIA

TRI-STATE MACHINE, INC., a West Virginia corporation,	:	
Plaintiff,	:	CIVIL ACTION NO.
v.	:	90-C-131B
NATIONWIDE LIFE INSURANCE COMPANY, an Ohio corporation,	:	
Defendant.	:	

COMPLAINT

The plaintiff, for its complaint against the defendant, states and alleges as follows:

COUNT I

(1) The plaintiff, Tri-State Machine, Inc. ("hereinafter "Tri-State"), was, at all times material hereto, a West Virginia corporation doing business in Ohio County, West Virginia.

(2) The defendant, Nationwide Life Insurance Company (hereinafter "Nationwide"), was, at all times material hereto, an Ohio corporation.

(3) The defendant has, prior to, during and subsequent to all times pertinent and relevant to this matter, been engaged in business in the State of West Virginia.

(4) From approximately November of 1983 through approximately July 1 of 1987, Nationwide contracted with

Tri-State to provide group health insurance for Tri-State's employees under a fixed premium plan.

(5) In 1987, Nationwide proposed a method of premium collection under the insurance contract, known as a "minimum premium plan" or "prefunding plan."

(6) Under the proposal deemed a "minimum premium" plan, Tri-State was led to believe that they would be and contractually should have been provided a monthly liability limitation, an individual stop loss protection and a rolling aggregate or yearly maximum out-of-pocket expense limitation under the insurance contract.

(7) On or about July 1, 1987, Nationwide contracted with Tri-State to provide group health insurance under a minimum premium plan for employees of Tri-State, said contract was to expire on June 30, 1988. Said contract was renewed on July 1, 1988, and on July 1, 1989.

(8) Under the policy, Tri-State was self-insured for certain portions of benefits payable under the group health insurance plan.

(9) Under the policy, Nationwide was responsible for certain benefits payable under the insurance contract over and above that portion for which Tri-State was self-insured.

(10) Nationwide collected premiums and derived economic benefits from its insurance contract with Tri-State.

(11) Nationwide had the duty to administer the employee health benefits program for Tri-State pursuant to the contract.

(12) Nationwide's duties included determining what claims should be paid and what claims should not be paid pursuant to the policy terms.

(13) Nationwide directly contracted with First Benefits Agency, Inc. to provide the administration services for the insurance policy in question herein and, more particularly, to administer the direct funding or minimum premium program referred to in previous paragraphs of this Complaint.

(14) Arch Turner, an employee of Nationwide, and Douglas Turner, an employee of First Benefits Agency, Inc., jointly presented the minimum premium plan to representatives of Tri-State. Douglas Turner is the son of Arch Turner.

(15) The agreement by and between Nationwide and Tri-State required, in part, that Nationwide provide monthly reports to Tri-State which would detail Tri-State's liability under the contract.

(16) Tri-State's liability under the contract and the minimum premium program was to be calculated based upon claims paid during any given policy year, subject to an individual and aggregate stop loss.

(17) During the month of July, 1989, Nationwide retroactively terminated the contract to be effective July 1, 1989. Prior to terminating the contract, Nationwide failed to timely process claims with the intent of imposing liability for these claims on Tri-State under the stop loss provisions which were renewed for the new plan year beginning July 1, 1989.

(18) Nationwide deliberately manipulated its calculations and processing of claims in violation of the contract so as to maximize Tri-State's termination liability after improperly terminating said contract as stated herein.

(19) Nationwide has asserted, and continues to assert, that Tri-State is liable for claims incurred and paid by Nationwide prior to termination, said action taken knowingly by Nationwide and directly contrary to the contract.

(20) Nationwide had a fiduciary duty to Tri-State to properly accomplish all duties under the administration program and the insurance contract.

(21) Nationwide did not administer the contract or the minimum funding program according to the terms of the respective contracts.

(22) Nationwide deliberately mismanaged the contract by, among other acts:

(a) Paying claims to the wrong medical providers;

(b) Issuing coverage cards in the names of employees never associated with Tri-State;

(c) Charging claims to the accounts of individuals who had not submitted said claims;

(d) Paying claims not covered;

(e) Denying claims that were covered;

(f) Inconsistently paying or denying claims dependent upon whether they were deemed to be the liability of Nationwide or Tri-State;

(g) Requesting reimbursement from Tri-State for claims improperly paid;

(h) Delayed processing of claims in a year during which Tri-State had met its stop loss liability and thus deflecting claims into a new policy year and thus the claims would become obligations of Tri-State under the renewal stop loss limit.

(23) Nationwide did not calculate Tri-State's monthly, individual and/or yearly liability in accordance with the contract of insurance due to improper administration of the contract.

(24) Nationwide did not provide monthly reports correctly reflecting the calculations concerning Tri-State's liabilites [sic] under the contract.

(25) Nationwide terminated the insurance contract in question in direct disregard and violation of the insurance contract and its provisions and the applicable laws of the State of West Virginia.

(26) Nationwide erroneously calculated premiums due from Tri-State and retroactively terminated the contract based upon a failure to pay the incorrect and erroneously calculated premiums, in violation of the contract and West Virginia law.

(27) Nationwide improperly calculated Tri-State's post-termination liability following the termination of the contract.

(28) Nationwide and First Benefits Agency, Inc., as an agent of Nationwide, manipulated postings to Tri-State's account, improperly calculated the various claims paid and deliberately misinformed Tri-State as to how their liability was calculated, in direct violation of the insurance contract and minimum premium agreement so as to maximize Tri-State's liability under the contract and minimize Nationwide's liability under the contract.

(29) During the contract term, Nationwide unilaterally changed the monthly and yearly stop loss of Tri-State without notice and in direct violation of the contract of insurance.

(30) Nationwide willfully, wantonly, maliciously, intentionally, fraudulently and deceptively breached its fiduciary duty to Tri-State under the contract in question.

(31) Nationwide's violations of the contract have caused Tri-State's employees to devote much time and attention to overseeing the administration of the contract and attempting to ascertain Nationwide's numerous violations thereof, all to the financial detriment of Tri-State.

(32) In doing the acts complained of herein Nationwide has caused harm to the employees of Tri-State, all of whom are third-party beneficiaries of said contract.

(33) Nationwide's cancellation of the contract left all Tri-State employees with *no* health insurance, including those with conditions which prohibited obtaining new coverage, causing great risk of emotional and financial damage.

(34) The actions of Nationwide, all in violation of the contract, have caused Tri-State Machine, Inc. much

aggravation, inconvenience and economic loss, including post-termination economic loss in obtaining new insurance at increased rates.

(35) The violations of the contract by Nationwide have caused Tri-State Machine, Inc. direct economic loss in that a proper administration of the policy would have resulted in a net liability to Tri-State under the policy in an amount lower than the amount ultimately calculated and collected by Nationwide.

(36) Nationwide has admitted that a limited audit requested by Tri-State revealed a twenty-six percent (26%) error rate in the handling of claims under the contract.

(37) Nationwide deliberately, intentionally, recklessly, maliciously and with bad motives failed to inform Tri-State in accordance with the contract.

(38) Nationwide deliberately, intentionally, recklessly, maliciously and with bad motives, failed to provide claims history information necessary for Tri-State to attempt to obtain insurance coverage for employees, following Nationwide's improper termination of the contract.

(39) All actions of Nationwide and First Benefits Agency, Inc., which have resulted in violations of the contract and direct and proximate damages to Tri-State and its owners, were done deliberately, intentionally, negligently, recklessly, maliciously, tortiously, fraudulently, deceptively, defiantly, willfully and wantonly, all said acts being designed to benefit Nationwide at Tri-State's expense.

(40) Nationwide has committed all acts complained of herein with such frequency as to indicate a general business practice of committing said acts.

COUNT II

(41) The plaintiff incorporates by reference all the allegations contained in Count I above, including paragraphs 1 through 40 as if set forth completely herein.

(42) Nationwide has breached its duties and obligations under the insurance contract referenced herein, and as a direct and proximate result thereof, Tri-State has incurred direct economic damages under the contract, consequential damages and legal fees and expenses, for all of which Nationwide is now liable.

COUNT III

(43) The plaintiff incorporates by reference all the allegations contained in Count I above, including paragraphs 1 through 40 as if set forth completely herein.

(44) In doing the acts and actions complained of above, the defendant, Nationwide, has breached implied covenants of good faith and fair dealing embodied in this particular contract, and all insurance contracts, and in doing so, has been negligent, reckless, malicious, tortious, fraudulent, deceptive, defiant, intentional, willful, wanton and deliberate.

COUNT IV

(45) The plaintiff incorporates by reference all the

allegations contained in Count I above, including paragraphs 1 through 40 as if set forth completely herein.

(46) in doing the acts and actions complained of above, the defendant, Nationwide, has acted deliberately, intentionally, willfully, wantonly, recklessly and maliciously, all said actions being a tort independent of all contract actions referenced herein and commonly known as the tort of "bad faith."

COUNT V

(47) The plaintiff incorporates by reference all the allegations contained in Count I above, including paragraphs 1 through 40 as if set forth completely herein.

(48) The plaintiff, Tri-State, is informed and believes that Nationwide is engaged in the business of providing insurance in the State of West Virginia and knowingly committed or performed with such frequency as to indicate a general business practice of the following acts, among others, defined by law as unfair claims settlement practices, in violation of the provisions of the Insurance Code of the State of West Virginia set forth below which were enacted for the benefit and protection of persons and corporations such as the plaintiff herein:

(a) Misrepresented pertinent facts of insurance policy provisions relating to coverages and duties at issue;

(b) Failed to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies;

(c) Failed to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies.

(49) In doing so, the defendant, Nationwide, committed a common law and statutory offense of "insurance bad faith."

COUNT VI

(50) The plaintiff incorporates by reference all the allegations contained in Count I above, including paragraphs 1 through 40 as if set forth completely herein.

(51) In doing the acts and omissions complained of as hereinbefore set forth, the defendant, Nationwide, violated the rules and regulations of the Insurance Commissioner of the State of West Virginia and, more specifically, Series XV-V-1981, Unfair Trade Practices, relating to deceptive and unfair trade practices, including unfair claim settlement practices.

PRAYER FOR RELIEF

WHEREFORE, the plaintiff, Tri-State Machine, Inc., demands judgment against Nationwide Life Insurance Company as follows:

(1) Compensatory damages in the sum of One Million Dollars ($1,000,000.00);

(2) Punitive damages in the sum of Ten Million Dollars ($10,000,000.00);

(3) Prejudgment and post-judgment interest on all items of ascertainable pecuniary loss up to and including

the date of trial or payment of the same, attorney fees and costs incurred in an attempt to protect Tri-State Machine, Inc.'s rights under the insurance contract in question;

(4) Judgment against Nationwide Life Insurance Company for all fees, expenses and costs incurred herein;

(5) The plaintiff demands a jury trial on all issues contained herein.

TRI-STATE MACHINE, INC.

By /s/ Ray A. Byrd
Of Counsel

By /s/ Gregory A. Gellner,
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IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF WEST VIRGINIA
(WHEELING DIVISION)

TRI-STATE MACHINE, INC., a West Virginia corporation,	:	CIVIL ACTION NO. ___
Plaintiff,	:	(Ohio County Circuit Court Civil Action No. 90-C-131 B)
v.	:	
NATIONWIDE LIFE INSURANCE COMPANY, an Ohio corporation,	:	
Defendant.	:	

PLAINTIFF'S MEMORANDUM OF
LAW IN SUPPORT OF MOTION TO REMAND

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A. *Cases*

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Brough v. United Steelworkers of America, AFL-CIO, 437 F.2d 748 (1st Cir. 1971)

Buchannan v. Delaware Valley News, 571 F. Supp. 868 (E.D. Pa. 1983)

Burgess v. Charlottesville Savings & Loan Ass'n, 477 F.2d 40 (4th Cir. 1973)

Caterpillar, Inc. v. Williams, 482 U.S. 386 (1987)

Champion International Corp. v. Brown, 731 F.2d 1406 (9th Cir. 1984)

Continental Resources and Mineral Corp. v. Continental Ins. Co., 546 F. Supp. 850 (S.D. W.Va. 1982)

Cook v. Georgetown Steel Corp., 770 F.2d 1272 (4th Cir. 1985)

County of Suffolk v. Long Island Lighting Co., 549 F. Supp. 1250 (E.D. N.Y. 1982)

Croy v. Buckeye International, Inc., 483 F. Supp. 402 (D. Md. 1979)

Cuyahoga Co. v. Northern Ohio Co., 252 U.S. 388 (1920)

Eversole v. Metropolitan Life Ins. Co., 500 F. Supp. 1162 (C.D. Cal. 1980)

Ferrell v. Heck's, Inc., 604 F. Supp. 683 (S.D. W.Va. 1985)

Freeman v. Colonial Liquors, Inc., 502 F. Supp. 367 (D. Md. 1980)

Fresh International Corp. v. Agricultural Labor Relations Bd, 805 F.2d 1353 (9th Cir. 1986)

Gully v. First National Bank, 299 U.S. 109 (1936)

Hudler v. Wilson, 376 F. Supp. 592 (D. Colo. 1974)

Hughes v. Blue Cross of Northern California, 263 Cal. Rptr. 850, 215 Cal. App. 3d 832 (1989)

Irving Trust Co. v. Century Export & Import, S.A., 464 F. Supp. 1232 (S.D. N.Y. 1979)

Jones v. General Tire & Rubbert [sic] *Co.*, 541 F.2d 660 (7th Cir. 1976)

Jones v. Rath Packing Co., 430 U.S. 519 (1977)

Kilgore v. McKethan, 205 F.2d 425 (5th Cir. 1953)

LaCoste v. The Alligator Company, Inc., 506 F.2d 339 (3d Cir. 1974)

Malone v. Gardner, 62 F.2d 15 (4th Cir. 1932)

Martinez v. Southern Ute Tribe, 273 F.2d 731 (10th Cir. 1960)

McCartney v. State of West Virginia, 156 F.2d 739 (4th Cir. 1946)

McCorkle v. First Pennsylvania Banking and Trust Co., 459 F.2d 243 (4th Cir. 1972)

Metropolitan Life Insurance Company v. Massachusetts, 471 U.S. 724 (1985)

Northbrook National Insurance Company v. Brewer, 493 U.S. ___, 107 L. Ed. 2d 223 (1989)

Northeast Nuclear Energy Company v. General Electric Company, 435 F. Supp. 344 (D. Conn. 1977)

Northwest Cent. Pipeline Corp. v. Mesa Petroleum Co., 576 F. Supp. 1495 (D.C. Del. 1983)

People by Atty. Gen. v. Glendale Federal Sav. & Loan Asso., 475 F. Supp. 728 (C.D. Cal. 1979)

Pilot Life Insurance Company v. Dedeaux, 481 U.S. 41 (1987)

Polhemus v. American Medical Ass'n, 145 F.2d 357 (10th Cir. 1944)

Rice v. Exxon Corporation, 631 F. Supp. 1522 (S.D. W.Va. 1986)

Russo v. Kirby, 453 F.2d 548 (2d Cir. 1971)

Screven County v. Brier Creek Hunting & Fishing Club, 202 F.2d 369 (5th Cir. 1953)

Seamon v. Bell Tel. Co., 576 F. Supp. 1458 (W.D. Pa. 1983)

Shamrock Oil & Gas Corp. v. Sheets, 313 U.S. 100 (1941)

Sharp v. AT&T Communications, 660 F. Supp. 650 (N.D. W.Va. 1987)

Shulthis v. McDougal, 225 U.S. 561 (1912)

Swank v. Patterson, 139 F.2d 145 (9th Cir. 1944)

Tafflin v. Levitt, 493 U.S. ___, 107 L. Ed. 2d 887 (1990)

Thomas v. Kroger Co., 583 F. Supp. 1031 (S.D. W.Va. 1984)

Trauss v. City of Philadelphia, 159 F. Supp. 672 (D.C. Pa. 1958)

Warner Bros. Records, Inc. v. R.A. Ridges Distributing Co., 475 F.2d 262 (10th Cir. 1973)

Warrington Sewer Company v. Tracy, 463 F.2d 771 (3d Cir. 1972)

B. *Federal Statutes*

28 U.S.C. § 1332 (attached)

28 U.S.C. § 1441 (attached)

29 U.S.C. § 1001 *et seq.*

29 U.S.C. § 1132 (attached)

29 U.S.C. § 1144 (attached)

42 U.S.C. § 2000 *et seq*

C. *State Statutes*

W. Va. Code, §§ 5-11-1 *et seq*

W. Va. Code, §§ 33-11-1 – 33-11-10

W. Va. Code, §§ 47-18-1 *et seq*

D. *Other*

13 C. Wright A. Miller & E. Cooper, *Federal Practice and Procedure*, § 3566 at 438 (1975)

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF WEST VIRGINIA
(WHEELING DIVISION)

TRI-STATE MACHINE, INC., a West Virginia corporation, Plaintiff, v. NATIONWIDE LIFE INSURANCE COMPANY, an Ohio corporation, Defendant.	CIVIL ACTION NO. ___ (Ohio County Circuit Court Civil Action No. 90-C-131 B)

PLAINTIFF'S MEMORANDUM OF LAW IN SUPPORT OF MOTION TO REMAND

I

STATEMENT OF FACTS

This action was brought in the Circuit Court of Ohio County, West Virginia against defendant for damages arising from a breach of contract by defendant to provide group health insurance for plaintiff's employees under a fixed premium plan. Specifically, it is alleged that defendant breached its duties to administer the benefits program and failed to determine what claims should be paid or what claims should not be paid. It is alleged that defendant failed to timely process claims with the intent of imposing liability on plaintiff under the stop-loss provisions of the plan, and that defendant deliberately mismanaged the contract. It is alleged that defendant breached its fiduciary duty to plaintiff and that defendant breached the implied covenants of good faith and fair dealing. It is also alleged that defendant misrepresented

pertinent facts of the insurance policy and committed the common law and statutory offense of "insurance bad faith." Further, it is alleged that defendant's actions violated the applicable laws of the State of West Virginia, including the rules and regulations of the Insurance Commissioner of the State of West Virginia and, more specifically, Series XV-V-1981, Unfair Trade Practices, relating to deceptive and unfair trade practices.

Defendant filed a notice of removal alleging that this Court has original jurisdiction over plaintiff's civil action pursuant to 29 U.S.C. §1001 *et seq.* (ERISA) and 28 U.S.C. §1332.

However, it is plaintiff's contention that its claim is based entirely and solely upon state law and does not invoke ERISA original jurisdiction.

II

RELEVANT ERISA PROVISIONS

ERISA comprehensively regulates, among other things, employee welfare benefit plans that, through the purchase of insurance or otherwise, provide medical, surgical, or hospital care, or benefits in the event of sickness, accident, disability, or death. 29 U.S.C. §1002(1).

Congress capped off the undertaking of ERISA with three provisions relating to the preemptive effect of the federal legislation as follows:

> Except as provided in subsection (b) of this section [the saving clause], the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as

> they may now or hereafter relate to any employee benefit plan. . . . §514(a), as set forth in 29 U.S.C. §1144(a) [29 U.S.C. §1144(a)] (pre-emption clause).
>
> Except as provided in subparagraph (B) [the deemer clause], nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities. §514(b) (2) (A), as set forth in 29 U.S.C. §1144(b) (2) (A) [29 U.S.C. §1144(b) (2) (A)] (saving clause).
>
> Neither an employee benefit plan . . . nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies. §514(b) (2) (B), 29 U.S.C. §1144(b) (2) (B) [29 U.S.C. §1144(b) (2) (B)] (deemer clause).

To summarize the mechanics of the provisions quoted above, if a state law relates to an employee benefit plan, it is preempted. §514(a). The saving clause excepts from the preemption clause those laws that regulate insurance. §514(b) (2) (A). The deemer clause makes it clear that a State law that purports to regulate insurance cannot deem an employee benefit plan to be an insurance company. §514(b) (2) (B). *Pilot Life Insurance Company v. Dedeaux*, 481 U.S. 41, 45 (1987).

III

DISCUSSION OF LEGAL ISSUES

A. 28 U.S.C. §1331 and 28 U.S.C. §1441(b) PROHIBIT THIS ACTION FROM BEING REMOVED SINCE PLAINTIFF'S CLAIM IS BASED ON STATE LAW AND DOES NOT INVOKE THE PRINCIPLES OF ORIGINAL JURISDICTION.

A plaintiff is the "master of the complaint." 13 C. Wright, A. Miller & E. Cooper, *Federal Practice and Procedure*, §3566 at 438 (1975). He may base his claim solely on state law and defeat a defendant's potential right to remove the cause of action where remedies exist under both state and federal law. *County of Suffolk v. Long Island Lighting Co.*, 549 F. Supp. 1250 (E.D. N.Y. 1982). With that in mind, a complaint states a removable cause of action only if it characterizes a lawsuit as an action for damages under a federal statute and its substantive allegations *clearly* state a federal cause of action. *Seamon v. Bell Tel. Co.*, 576 F. Supp. 1458 (W.D. Pa. 1983). Removal will not be granted on the probability or possibility that a federal question will arise in subsequent proceedings. *Northwest Cent. Pipeline Corp. v. Mesa Petroleum Co.*, 576 F. Supp. 1495 (D.C. Del. 1983). The federal question must be an essential element of a plaintiff's cause of action and a district court is prohibited from looking beyond the complaint to find such a basis for removal. *Jones v. General Tire & Rubber Co.*, 541 F.2d 660 (7th Cir. 1976); *People by Atty. Gen. v. Glendale Federal Sav. & Loan Asso.*, 475 F. Supp. 728 (C.D. Cal. 1979).

The plaintiff herein has based its breach of contract lawsuit on state law with no reference at all to any type of

federal claim. The intent of the plaintiff to pursue its state claim is clear. Plaintiff's civil action is a pure bad faith action seeking remedies within the rules and regulations of the West Virginia Unfair Trade Practices Act, *W. Va. Code*, §§33-11-1 and 33-11-10 (1982). Nevertheless, the defendant urges this Court to disregard the plaintiff's own statement of its claim and recast the issues in a federal light.

It is well-settled in this district that removal statutes are to be strictly construed against removal. *Thomas v. Kroger Co.*, 583 F. Supp. 1031 (S.D. W.Va. 1984); *Continental Resources and Mineral Corp. v. Continental Ins. Co.*, 546 F. Supp. 850 (S.D. W.Va. 1982). Removal of civil cases to a federal court is an infringement on state sovereignty. Accordingly, courts should not extend their jurisdiction beyond the boundaries drawn by the removal statutes. *Shamrock Oil & Gas Corp. v. Sheets*, 313 U.S. 100 (1941). Under the circumstances of this case, the defendant's rephrasing of the issues contravenes the well-established principle that the removal statute is to be strictly construed, and that the exercise of federal jurisdiction is to be rejected in doubtful cases. *Croy v. Buckeye International, Inc.*, 483 F. Supp. 402 (D. Md. 1979); *Irving Trust Co. v. Century Export & Import, S.A.*, 464 F. Supp. 1232 (S.D. N.Y. 1979).

Where a plaintiff's claim involves both a federal ground and a state ground, the plaintiff is free to ignore the federal question and pursue his claim on the state ground, precluding removal based on the existence of a federal question. *Buchannan v. Delaware Valley News*, 571 F. Supp. 863 (E.D. Pa. 1983); *Warner Bros. Records, Inc. v. R. A. Ridges Distributing Co.*, 475 F.2d 262 (10th Cir. 1973);

Brough v. United Steelworkers of America, AFL-CIO, 437 F.2d 748 (1st Cir. 1971); *LaCoste v. The Alligator Company, Inc.*, 506 F.2d 339 (3d Cir. 1974).

Furthermore, the existence of federal jurisdiction on removal must be determined on the face of the plaintiff's complaint. *Gully v. First National Bank*, 299 U.S. 109 (1936). This principle is often referred to a [sic] the "well-pleaded complaint" rule, which provides that federal jurisdiction exists only when a federal question is presented on the face of a properly-pleaded complaint. *Caterpillar, Inc. v. Williams*, 482 U.S. 386 (1987). In *Caterpillar*, the United States Supreme Court held that the well-pleaded complaint rule makes the plaintiff the master of his claim and enables the plaintiff to avoid federal jurisdiction by exclusive reliance on state law. Accordingly, the plaintiff herein has relied on the claims and remedies set forth in the West Virginia Unfair Trade Practices Act and West Virginia contract law, without reference to or reliance on federal law.

Whether removal is proper under 28 U.S.C. §1441(b) hinges on the defendant's assertion that the plaintiff's claim "arises under federal law" under the principles of original jurisdiction pursuant to 28 U.S.C. §1331. However, an examination of Fourth Circuit law and a trilogy of West Virginia district court decisions clearly reveal that plaintiff's case should be remanded to the Circuit Court of Ohio County, West Virginia.

In *Burgess v. Charlottesville Savings & Loan Ass'n*, 477 F.2d 40 (4th Cir. 1973), the Fourth Circuit remanded the plaintiff's claim to state court after ruling that the issues raised in the complaint presented no federal question and

were determinable solely by state law. The plaintiff's action in *Burgess* was one to recover for breach of a contract to procure life insurance. In setting forth such a cause of action in her complaint, the plaintiff included among her allegations the form of notice required by Federal Reserve Regulation Z under the Truth in Lending Act, and based one count of her action on the claim that the failure of the defendant to procure certain life insurance violated Regulation Z of the Truth in Lending Act. The plaintiff's claim in *Burgess* differs from the plaintiff's claim herein in that Burgess based one count on a federal claim where the plaintiff herein has relied entirely on state law with no reference to any federal claims. Because the plaintiff's claim in *Burgess* was made under the Truth in Lending Act, the defendant removed the action to federal court as one "arising under the laws of the United States" under 28 U.S.C. §1441(b).

The District Court for the Western District of Virginia, after finding federal jurisdiction on the ground that the case involved construction and interpretation of federal law, to-wit, the federal Truth in Lending Act, dismissed the action holding there was no evidence that a contract to procure insurance was ever formed. However, the Fourth Circuit disagreed and remanded the cause of action to the state court from which it was removed.

In support of its well-reasoned ruling, the Fourth Circuit placed great emphasis on the principle that cases predicated entirely on the claim that the suit "arises under" federal law are to be resolved on the basis of the allegations of the complaint itself which "affirmatively and distinctly" must establish federal grounds "not in mere form, but in substance," and "not in mere assertion,

but in essence and effect." *Burgess*, 477 F.2d at 43, citing *Barnhart v. Western Maryland Ry. Co.*, 128 F.2d 709, 714 (4th Cir. 1942), and *Cuyahoga Co. v. Northern Ohio Co.*, 252 U.S. 388, 397 (1920). Mere conclusory allegations in the complaint are insufficient to support federal jurisdiction. *Burgess, Id.; Martinez v. Southern Ute Tribe*, 273 F.2d 731 (10th Cir. 1960). As one court expressed it,

> [I]f the concept of federal question is to have any meaning, the court must look beyond the verbiage of a complaint to the substance of the plaintiff's grievance, and dismiss the action, where no real basis for federal jurisdiction exists.[1]

The *Burgess* court fully expanded on the importance of the distinction between claims based upon state law and allegations that such claims "arise under" federal law and reasoned as follows:

> [T]he mere assertion in a pleading that the case is one involving the construction or application of the federal laws does not authorize the district court to entertain the suit nor does federal jurisdiction attach on the bare assertion that a federal right or law has been infringed or violated or that the suit "takes its origin in the laws of the United States." To satisfy the statutory jurisdictional requirement, a federal right must be a "real and substantial" issue in the case and "must be an element of the plaintiff's cause of action. It is often true that, a mere incidental or collateral federal question may appear, or may lurk in the background of the record, but this is

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[1] *Trauss v. City of Philadelphia*, 159 F. Supp. 672, 676 (D.C. Pa. 1958).

> not a sufficient or adequate basis upon which federal jurisdiction may attach. Simply stated, an action arises under federal law only if it really and substantially involves a dispute or a controversy respecting the validity, construction or effect of such a law, upon which the determination of which the result depends. In ascertaining whether there is a real federal issue upon which the result depends, the courts have observed the distinction between controversies that are basic and those that are collateral, between disputes that are necessary and those that are merely possible, and federal question jurisdiction attaches only to cases where the plaintiff's cause of action, the rule of substance under which he claims the right to have a remedy, is a product of federal law.[2]

The Fourth Circuit in *Burgess* agreed with the plaintiff that the real basis upon which she premised her cause of action was an alleged contract or agreement to procure insurance, the breach of which, under her theory, gave rise to an action both in contract and in tort under the laws of Virginia. Whether the contract was designed to comply with the Truth in Lending Act or not was unimportant according to the Court since the basic issue in the

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[2] *Burgess, Id.* at 43 and 44, relying upon and citing *Malone v. Gardner,* 62 F.2d 15, 18 (4th Cir. 1932); *McCartney v. State of West Virginia,* 156 F.2d 739 (4th Cir. 1946); *Kilgore v. McKethan,* 205 F.2d 425, 426 (5th Cir. 1953); *Polhemus v. American Medical Ass'n,* 145 F.2d 357 (10th Cir. 1944); *Russo v. Kirby,* 453 F.2d 548 (2d Cir. 1971); *Swank v. Patterson,* 139 F.2d 145 (9th Cir. 1944); *Shulthis v. McDougal,* 225 U.S. 561 (1912); *McCorkle v. First Pennsylvania Banking and Trust Co.,* 459 F.2d 243 (4th Cir. 1972); *Screven County v. Brier Creek Hunting & Fishing Club,* 202 F.2d 369 (5th Cir. 1953); *Warrington Sewer Company v. Tracy,* 463 F.2d 771 (3d Cir. 1972).

case was whether the language used by the defendant in its form of loan application was sufficient to be the basis for the creation of a contractual right which was determinable solely by Virginia law, not federal law. *Burgess, Id.* at 44.

In a trilogy of decisions, the United States District Court for both the Northern and Southern Districts of West Virginia have followed and upheld the ruling in *Burgess.*

In the most recent of the decisions, *Sharp v. AT&T Communications,* 660 F. Supp. 650 (N.D. W.Va. 1987), Judge Kidd remanded the plaintiff's claim against her employer based on insufficient evidence to invoke federal jurisdiction under 28 U.S.C. §1441. In *Sharp,* the plaintiff's complaint alleged two causes of action for breach of contract and the tort of outrageous conduct against the defendant. The defendant removed the claim to federal court pursuant to 28 U.S.C. §1441 alleging that the matter presented federal question jurisdiction based upon a collective bargaining agreement between the parties. However, the district court disagreed and remanded the case to the Circuit Court of Marion County, West Virginia.

The Court in *Sharp* stated the settled rule of law that a federal question must appear on the face of a plaintiff's well-pleaded complaint. *Cook v. Georgetown Steel Corp.,* 770 F.2d 1272 (4th Cir. 1985). The Court further ruled that when a plaintiff presents a state law claim and the defendant counters by arguing that federal law preempts the state law upon which the plaintiff relies, the federal claim appears by way of defense. *Sharp,* 660 F. Supp. at 651, citing *Champion International Corp. v. Brown,* 731 F.2d 1406

(9th Cir. 1984). In that regard, the defense that federal law has preempted the state law upon which the plaintiff relies does not itself create a federal question for purposes of the removal statute. *Sharp, Id.* Although a matter raises substantial issues under both state and federal laws, if a well-pleaded complaint does not invoke federal law, jurisdiction does not exist. *Sharp, Id.*, citing *Georgetown Steel Corp., supra,* at p. 276.

It was apparent to the Court that the plaintiff's claim in *Sharp* was cast in state law and nothing was being sought under the collective bargaining agreement. Thus the case was remanded to circuit court.

In the next decision, Judge Haden, in *Rice v. Exxon Corporation,* 631 F. Supp. 1522 (S.D. W.Va. 1986), remanded a case to the Circuit Courts of Jackson and Kanawha counties on the ground that no federal question was raised by the plaintiff's complaint. In *Rice,* the plaintiff alleged specific counts citing provisions of the West Virginia Antitrust Act, *W. Va. Code,* §§47-18-1 *et seq.*, which the defendant allegedly violated. The defendant alleged that the plaintiff's claim arose under the Constitution or laws of the United States.

However, the district court in *Rice* disagreed and ruled that in determining whether a case arises under the Constitution or laws of the United States, the Court must examine the complaint itself to determine whether a cause of action under federal law is disclosed. *Rice,* 631 F. Supp. at 1524, citing *Gully v. First National Bank,* 299 U.S. 109 (1936). The Court further stated that where a plaintiff's claim involves both a federal ground and a state ground, the plaintiff is free to ignore the federal question

and to premise his claim on the state ground, precluding removal based upon the existence of a federal question. *Rice, Id.*, citing *Buchannan v. Delaware Valley News*, 571 F. Supp. 868, 871 (E.D. Pa. 1983). Similarly, while the position could be taken that the plaintiff's complaint herein arguably involves a federal claim because it involves group health insurance, the plaintiff is nevertheless free to ignore the federal question and to pursue its claim on state grounds.

In the last of the trilogy of remand cases, Judge Haden again ruled in *Ferrell v. Heck's, Inc.*, 604 F. Supp. 683 (S.D. W.Va. 1985), that the complaint alleged only state law-based causes of action that did not authorize removal to federal court, and thus remanded the case to the Circuit Court of Kanawha County. In *Ferrell*, the plaintiff alleged breach of contract and violations of the West Virginia Human Rights Act, *W. Va. Code*, §§ 5-11-1 *et seq.* The defendant removed the case on the basis that the plaintiff's action was brought pursuant to Title VII of the Civil Rights Act of 1964, 42 U.S.C. § 2000(e) *et seq.* However, the Court agreed with the plaintiff's assertions that she alleged only state law-based causes of action, namely, breach of contract and violations of *W. Va. Code*, §§ 5-11-1 *et seq.* The Court stated as follows:

> The fact that the plaintiff *could have* pursued her sex discrimination claim via Title VII is irrelevant. The plaintiff is the architect of her own lawsuit and "is entitled to allege only non-federal claims, even though [she] could have relied also on federal law." (emphasis added).

Ferrell, Id. at 684; *Freeman v. Colonial Liquors, Inc.*, 502 F. Supp. 367, 369 (D. Md. 1980).

Other jurisdictions have addressed removal to federal court based on ERISA original jurisdiction. Accordingly, it has been held that a federal court does not have jurisdiction over an employee's claims against an employee benefit plan under 29 U.S.C. §1132, where the employee chooses not to assert his ERISA claims but to rely solely on his state law causes of action. *Eversole v. Metropolitan Life Ins. Co.*, 500 F. Supp. 1162 (C.D. Cal. 1980).

It has also been held that a federal court lacks jurisdiction under ERISA over a breach of contract suit involving an employer's severance policy where the complaint can be read so that plaintiffs could concede defendant's full compliance with the Act and still maintain the action, thus making the policy's compliance with ERISA irrelevant to the essential issues of the lawsuit. *Bell v. Amcast Industrial Corp.*, 607 F. Supp. 486 (S.D. Ohio (1985). Furthermore, it has been held that a federal court properly abstained from exercising jurisdiction over a state court action where ERISA preemption was raised as a defense and was not readily apparent, since even if preemption would deprive the state court of jurisdiction it could still determine the validity of the defense. *Fresh International Corp. v. Agricultural Labor Relations Bd.*, 805 F.2d 1353 (1986).

The plaintiff's claim herein does not involve a claim for benefits which were denied. The lawsuit addresses various theories of liability, including breach of contract, breach of the implied covenant of good faith and fair dealing, statutory bad faith and violations of West Virginia insurance rules and regulations. Thus, the lawsuit is

predicated upon West Virginia state law which does not invoke the principles of original jurisdiction.

B. 29 U.S.C. §1132(e) PROHIBITS THIS ACTION FROM BEING REMOVED SINCE THE CIRCUIT COURT OF OHIO COUNTY, WEST VIRGINIA HAS CONCURRENT JURISDICTION OVER PLAINTIFF'S CLAIM.

Even assuming *arguendo* that removal is not prohibited by virtue of the lack of original jurisdiction, removal is prohibited by 29 U.S.C. §1132(e) since the Circuit Court of Ohio County, West Virginia has concurrent jurisdiction over plaintiff's claim. In this regard, the Court of Appeals for the First Appellate District of California ruled in *Hughes v. Blue Cross of Northern California*, 263 Cal. Rptr. 850, 215 Cal. App. 3d 832 (1989), that an action against a group health insurer alleging a breach of the covenant of good faith and fair dealing in connection with the denial of coverage for psychiatric hospitalization fell within the concurrent jurisdiction of federal and state courts under ERISA as an action to recover benefits and to enforce rights under the terms of the plan. The Court in *Hughes* ruled that the state court had jurisdiction over the claims made by the plaintiff under 29 U.S.C. §1132(e)(1) which provides:

> (e) Jurisdiction. (1) Except for actions under subsection (a) (1) (B) of this section, the district courts of the United States shall have exclusive jurisdiction of civil actions under this title brought by the Secretary or by a participant, beneficiary, fiduciary. State courts of competent jurisdiction and district courts of the United States shall

> have *concurrent jurisdiction* of actions under subsection (a)(1)(B) of this section. (Emphasis added).

Accordingly, 29 U.S.C. §1132(a)(1)(B) provides:

> (a) Persons empowered to bring a civil action. A civil action may be brought –
>
> (1) by a participant or beneficiary –
>
> (B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan.

The *Hughes* court went on to further state that the exception to subsection (a)(1)(B) is a broad one. Thus, if this Court determines that the allegations made by the plaintiff invoke ERISA jurisdiction, the action should clearly be characterized as either one to enforce rights under the terms of the plan, or to clarify rights under the terms of the plan. Therefore, this action should be remanded to the Circuit Court of Ohio County, West Virginia since that court is a state court of competent jurisdiction as those terms are referred to in 29 U.S.C. §1132(e).[3]

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[3] Also upholding the principles of concurrent jurisdiction was the Court's ruling in *Tafflin v. Levitt*, 493 U.S. ___, 107 L. Ed. 2d 887 (1990). In *Tafflin*, the Court ruled that state courts have concurrent jurisdiction to hear civil claims arising under RICO, since RICO rules and regulations borrow heavily from state law.

C. 29 U.S.C. §1144(b)(2) PROHIBITS THIS ACTION FROM BEING REMOVED SINCE PLAINTIFF'S CLAIM IS BASED UPON STATE LAW "WHICH REGULATES INSURANCE."

The plaintiff's lawsuit alleges violations of the West Virginia Unfair Trade Practice Act, and such lawsuits are commonly referred to as "bad faith" actions. As such, the plaintiff is relying on the regulations set forth in *W. Va. Code*, §§33-11-1 and 33-11-10, for its remedies. This statutory authority regulates the insurance industry throughout the State of West Virginia and outlines the specific violations within which an aggrieved party may rely. Because this statute is one which regulates insurance, the saving clause prevents the state law from being preempted.

The Supreme Court has ruled that a common-sense view of the word "regulates" leads to the conclusion that in order to regulate insurance, a law must not just have an impact on the insurance industry, but must be specifically directed toward that industry. *Pilot Life Insurance Company v. Dedeaux*, 481 U.S. 41, 50 (1987). Thus, the roots of the West Virginia laws of "bad faith" with the insurance industry are firmly planted in general principles of West Virginia insurance regulatory law.

The United States Supreme Court addressed this specific issue in *Metropolitan Life Insurance Company v. Massachusetts*, 471 U.S. 724 (1985). Metropolitan Life addressed certain exceptions to the preemption doctrine involving ERISA claims. The court ruled that a Massachusetts statute requiring that specific minimum mental health-care benefits be provided in insurance policies was

not preempted by ERISA. The attorney general of Massachusetts brought suit in Massachusetts for declaratory and injunctive relief against out-of-state insurers to force them to comply with a Massachusetts statute which required minimum mental health care benefits to Massachusetts residents insured under a general insurance policy, an accident or sickness insurance policy, or an employee health care plan that covered hospital and surgical expenses. The insurers contended that the state statute was preempted by ERISA, and that the statute, as applied to insurance policies purchased pursuant to a negotiated collective-bargaining agreement, was preempted by the National Labor Relations Act (NLRA).

The Superior Court of Massachusetts issued a permanent injunction requiring the insurers to provide the coverage mandated by the state statute, and the Supreme Judicial Court of Massachusetts affirmed, finding no preemption under either ERISA or the NLRA. The United States Supreme Court affirmed in a unanimous opinion and ruled that while the state statute related to pension plans governed by ERISA so as to fall within the broad preemption provision of ERISA (29 U.S.C. §1144(a)), the state statute was saved by preemption by 29 U.S.C. §1144(b)(2) as a law "which regulates insurance."

The Court held that plans that purchase insurance, so-called "insurance plans," are directly affected by state laws that regulate the insurance industry. *Metropolitan Life, Id.* at 732. Furthermore, since nothing in ERISA regulates the content of welfare plans, the Court ruled that State regulation of insurance that indirectly affects the contents of welfare plans is *not* preempted by ERISA. *Id.* at 736.

After discussing the presumption that Congress did not intend to preempt areas of traditional state regulations as stated in *Jones v. Rath Packing Co.*, 430 U.S. 519 (1977), the Court in *Metropolitan Life* discussed the saving clause as it related to the deemer clause, and ruled:

> This common-sense view of the matter, moreover, is reinforced by the language of the subsequent subsection of ERISA, the "deemer clause," which states that an employee-benefit plan shall not be deemed to be an insurance company "for purposes of any law of any State purporting to regulate insurance companies, *insurance contracts*, banks, trust companies, or investment companies. §514(b)(2)(B), 29 U.S.C. §1144(b)(2)(B) [29 U.S.C. §1144(b)(2)(B)] (emphasis added). By exempting from the saving clause laws regulating insurance contracts that apply directly to benefit plans, the deemer clause makes explicit Congress' intention to include laws that regulate insurance contracts within the scope of the insurance laws preserved by the saving clause. Unless Congress intended to include laws regulating insurance contracts within the scope of the insurance savings clause, it would have been unnecessary for the deemer clause explicitly to exempt such laws from the saving clause when they are applied directly to benefit plans.

Metropolitan Life, Id. at 741.

Accordingly, if this Court finds that the plaintiff's claims invoke original jurisdiction under ERISA, the claims must surely fall under a state law "which regulates insurance" which would then be saved from preemption by virtue of the saving clause. Also, the group health

insurance contract in dispute should be considered an "insurance contract" saved from preemption by virtue of the deemer clause. Therefore, plaintiff's claim should be remanded to the Circuit Court of Ohio County, West Virginia.

D. 28 U.S.C. §1322(c) PROHIBITS THIS ACTION FROM BEING REMOVED SINCE DIVERSITY OF CITIZENSHIP DOES NOT EXIST.

The defendant carries the burden of proof to demonstrate its diversity of citizenship. *Northeast Nuclear Energy Company v. General Electric Company,* 435 F. Supp. 344 (D. Conn. 1977). In that regard, the United States Supreme Court in *Northbrook National Insurance Company v. Brewer,* 493 U.S. ___, 107 L. Ed. 2d 222 (1989), ruled that for diversity purposes, an insurer is a citizen of the same state as the insured in a direct action against a liability insurer. The plaintiff herein is a resident of the State of West Virginia. As such, in its direct action against the defendant, Nationwide Life Insurance Company, the defendant is considered a resident of the State of West Virginia for purposes of this lawsuit based upon the ruling set forth in *Northbrook.*

In *Northbrook,* the diversity of citizenship proviso under 28 U.S.C. §1332(c) was held not to apply to a workers' compensation action brought by the insurer. The plaintiff had filed a workers' compensation claim against Northbrook after he allegedly suffered an injury during the course of his employment, and the Texas Industrial Accident Board processed his claim and awarded him

compensation. The Texas workers' compensation law permitted any party dissatisfied with a Board ruling to file a civil suit to set the decision aside. As a result, *Northbrook* filed suit against *Brewer* in federal district court invoking the court's diversity jurisdiction under 28 U.S.C. §1332. The district court dismissed for lack of subject-matter jurisdiction on precedent that required it to apply the direct action proviso of the diversity statute. That proviso states:

> In any direct action against the insurer of a policy or contract of liability insurance, whether incorporated or unincorporated, to which action the insured is not joined as a party-defendant, the insurer shall be deemed a citizen of the State of which the insured is a citizen, as well as of any State by which the insurer has been incorporated and of the State where it has its principal place of business.

28 U.S.C. §1332(c).

The district court in *Northbrook* attributed the plaintiff's employer's Texas citizenship to Northbrook, eliminating diversity between Northbrook and the plaintiff. The Court of Appeals affirmed, but the United States Supreme Court reversed holding that the direct action proviso was not applicable because Northbrook's suit was an action *by*, not against, an insurer.

However, the plaintiff's claim herein is a direct action *against* an insurer. As such, the direct action proviso applies, and the defendant should be considered a resident of the State of West Virginia for diversity purposes. Accordingly, diversity of citizenship does not exist between the plaintiff and the defendant.

Also, in *Hudler v. Wilson*, 376 F. Supp. (D. Colo. 1974), multiple defendants attempted to remove a state court action to the district court in Colorado. The district court held that such an action on the basis of diversity was not removable because one of the parties who had been properly joined was a resident of Colorado, and therefore, removal was prohibited under 28 U.S.C. §1441(b).

The plaintiff requests that the same reasoning be applied to its claim to remand this civil action to the Circuit Court of Ohio County, West Virginia.

IV

CONCLUSION

For all the reasons set forth herein, plaintiff requests that this action be remanded to the Circuit Court of Ohio County, West Virginia, and that the Court assess costs and fees, and make a determination of whether or not the notice of removal was filed in good faith.

TRI-STATE MACHINE, Plaintiff

By /s/ Ray A. Byrd
Of Counsel

CERTIFICATE OF SERVICE

Service of the foregoing Plaintiff's Memorandum of Law in Support of Motion to Remand was had upon the defendant by mailing a true copy thereof, by United States mail, postage prepaid, to its counsel of record, on this 23rd day of April, 1990, as follows:

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No. 94-972

In The Supreme Court of the United States

October Term, 1994

TRI-STATE MACHINE, INC.,

Petitioner,

v.

NATIONWIDE LIFE INSURANCE COMPANY,

Respondent.

Petition For Writ Of Certiorari To The United States Court Of Appeals For The Fourth Circuit

BRIEF OF *AMICUS CURIAE* IN SUPPORT OF GRANT OF TRI-STATE MACHINE, INC.'S PETITION FOR WRIT OF CERTIORARI

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IDENTITY OF AMICUS CURIAE

This brief is filed by the Attorney General of the State of West Virginia as an *amicus curiae* on behalf of the State of West Virginia. Consent of the parties to the filing of this brief is not necessary under Rule 37.5 of the Rules of the Supreme Court.

INTEREST OF AMICUS CURIAE

West Virginia has an interest in seeing that its laws have force and effect. West Virginia has an interest in limiting federal involvement in matters of traditional state concern, such as insurance. Both employers and employees in the State of West Virginia have an interest in minimizing the cost of employer-sponsored health care. West Virginians, the West Virginia Attorney General and the West Virginia Insurance Commissioner all have an interest in seeing that West Virginia businesses are protected from unfair and fraudulent insurance practices.

Other than these important general interests, West Virginia and its Attorney General have no specific interest, proprietary or otherwise, in the parties to this action or their dispute.

SUMMARY OF ARGUMENT

West Virginia has a strong interest in deterring insurance fraud. The West Virginia Attorney General, like the Attorney General of any State, cannot be effective as the sole responsible body for policing and enforcing the sale of all employee benefit insurance products within a state. Insurance purchasers, having a direct, personal interest in the terms and conditions of an insurance contract, are best equipped to prevent fraud and abuse in the insurance industry due to their knowledge and familiarity with the terms and conditions of the insurance products which they have purchased.

The individual and collective ability of insurance purchasers to bring suit to redress unfair and fraudulent practices in the sale of insurance is the most effective means of ensuring that insurance sellers will comply with state insurance law. To that end, it is of vital concern to the State of West Virginia that Tri-State Machine, Inc. (''Tri-State'') have the ability to hold Nationwide Life Insurance Company (''Nationwide'') accountable for Nationwide's alleged breaches of contract and violations of West Virginia insurance law. Otherwise, insurance sellers will be able to protect themselves from suit by raising the ERISA preemption shield and will have little or no incentive to comply with state law in the sale of employee benefit insurance products.

The Fourth Circuit majority opinion in this case has a significant negative impact on the interest of West Virginia employers and employees. That opinion extends the scope of ERISA preemption to run-of-the-mill insurance purchasers so as to void West Virginia state laws and negate private causes of action in the context of employer-sponsored health care.

The case in question should be heard by the Supreme Court of the United States because it has substantial repercussions affecting state insurance law and the sale of insurance products throughout the United States.

ARGUMENT

A. Background

Congress has unequivocally spoken on the subject of insurance regulation and has plainly provided that the States shall have the exclusive authority to regulate the business of insurance. The McCarran-Ferguson Act provides that " . . . the continued regulation and taxation by the several States of the business of insurance is in the public interest, and . . . silence on the part of the Congress shall not be construed to impose any barrier to the regulation or taxation of such business by the several states." McCarran-Ferguson Act, 15 U.S.C. § 1011 *et seq.* (1988).

The Employee Income Retirement Security Act of 1974 broadly preempts state law, but excepts from preemption state laws which regulate insurance. 29 U.S.C. § 1144(b)(2)(A) (1988).

As the West Virginia Supreme Court of Appeals has recognized, West Virginia has a very strong interest in protecting West Virginia residents from unfair and fraudulent insurance practices. *Jenkins v. J. C. Penney Casualty Ins. Co.*, 280 S.E.2d 252 (W. Va. 1981). This interest is protected through state common law and statutory rights.

West Virginia's Unfair Trade Practices Act, W. Va. Code §§ 33-11-1 *et seq.* (the "Act"), is found within the chapter of the West Virginia Code entitled "Insurance." The Act was derived from the model act proposed by the National Association of Insurance Commissioners. The Act was promulgated pursuant to

the McCarran-Ferguson Act in an attempt to protect the consumers of insurance products against unfair and fraudulent insurance company practices. W. Va. Code § 33-11-1 (1974).[1]

Although the West Virginia Insurance Commissioner has the principal power to enforce the Unfair Trade Practices Act W. Va. Code § 33-2-3 (''Duties of commissioner''); 33-2-11 (''Enforcement of order; revocation of licenses; court action''); 33-11-6 (''Violations, cease and desist and penalty orders and violations thereof''), these administrative powers were not intended to be the exclusive remedy for violations of the statute. *Jenkins v. J. C. Penney Casualty Ins. Co.*, 280 S.E.2d 252, 257 (W. Va. 1981).

Rather, courts have appropriately determined that an implied private cause of action exists for violation of the Act because of West Virginia's strong interest in thwarting unfair insurance practices. *E.g., id.; Mutafis v. Erie Ins. Exch.*, 561 F. Supp. 192 (N.D. W. Va. 1983), *aff'd*, 775 F.2d 593 (4th Cir. 1985). Thus, private parties have the right to bring causes of action directly against insurance companies, for compensatory and punitive damages, to remedy violations of the Act. *Jenkins v. J. C. Penney Casualty Ins. Co.*, 280 S.E.2d 252 (W. Va. 1981); *Mutafis v. Erie Ins. Exch.*, 561 F. Supp. 192 (N.D. W. Va. 1983), *aff'd*, 775 F.2d 593 (4th Cir. 1985); *Weese v. Nationwide Ins. Co.*, 879 F.2d 115 (4th Cir. 1989).

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[1]That section states:

§ 33-11-1. Declaration of purpose.

The purpose of this article is to regulate trade practices in the business of insurance in accordance with the intent of Congress as expressed in the act of Congress of March ninth, one thousand nine hundred forty-five (Public Law fifteen, seventy-ninth Congress), by defining, or providing for the determination of, all such practices in this State which constitute unfair methods of competition or unfair or deceptive acts or practices and by prohibiting the trade practices so defined or determined.

Similarly, West Virginia law recognizes other common law causes of action, such as breach of the covenant of good faith and fair dealing, that serve to protect West Virginians from unfair and fraudulent insurance practices. *E.g., Weese v. Nationwide Ins. Co.*, 879 F.2d 115 (4th Cir. 1989).

B. West Virginia has an Important Interest at Stake

West Virginia has a strong interest in seeing that its state laws regulating the sale of insurance are saved from preemption. Many courts, including the Supreme Court of West Virginia, have recognized a very important fact: The right of a person injured as a result of unfair insurance practices to recover compensatory and punitive damages and attorneys fees acts as a strong deterrent against wrongful conduct. *See, e.g., Jenkins v. J. C. Penney Casualty Ins. Co.*, 280 S.E.2d 252, 258 (W. Va. 1981); *Mutafis v. Erie Ins. Exch.*, 561 F. Supp. 192, 200 (N.D. W. Va. 1983), *aff'd*, 775 F.2d 593 (4th Cir. 1985).

The West Virginia government expends a substantial amount of time, energy and taxpayer funds to monitor insurance company practices and to enforce the Unfair Trade Practices Act, but these measures are not a sufficient deterrent to unfair and fraudulent sales practices. West Virginia's regulation of insurance sales practices can be truly effective only when buttressed by the right of employers and other insurance purchasers to bring actions in their own right.

As one court stated, the potential for liability created by recognizing a private cause of action is a deterrent as well as "an effective tool in securing compliance with the Act." *Mutafis*, 561 F. Supp. at 200.

In the case at issue, it is alleged by a West Virginia employer that Nationwide Life Insurance Company fraudulently deceived the employer in the sale of an insurance product and the computation of insurance premiums. Under West Virginia

state laws, if these allegations were proven to be true, the employer would have a private cause of action under the Unfair Trade Practices Act. Such insurance purchaser would also have a contract action for breach of the covenant of good faith and fair dealing, as well as tort claims.[2]

Because of the number of insurance companies doing business in West Virginia, the variety of insurance products marketed, and the sheer volume of insurance sold to West Virginia residents, the right of purchasers of insurance to enforce provisions of the Act as they affect the conduct of insurance companies in any particular situation is important to the overall effectiveness of the Act.

The more an employer is protected against unfair insurance practices, the greater the benefits the employer can provide for the same expenditure. In the case at issue, Tri-State would have to pay less for insurance if Nationwide, the company providing health care coverage, were defeated in its alleged attempt to fraudulently collect more premiums than due.

The Fourth Circuit opinion in question insulates an insurance company from fraudulent sales practices under the rationale that this is a matter of important federal concern that Congress intended to preempt. To the contrary, Congress intended to insulate insurance companies against claims by employee benefit plan beneficiaries and participants seeking to enhance their federal remedies provided by ERISA. No such similar rationale exists to protect insurance companies from their misdeeds in selling insurance and calculating insurance premiums from an employer who voluntarily sponsors an ERISA plan.

---

[2]The remedies available under state law could include punitive damages and attorney's fees if Tri-State were able to prove wilful, malicious or intentional conduct. *See Jenkins v. J. C. Penney Casualty Ins. Co.*, 280 S.E.2d 252, n.12 (W. Va. 1981); *Mutafis v. Erie Ins. Exch.*, 775 F.2d 595 (1985); *Hayseeds, Inc. v. State Farm Fire & Casualty*, 352 S.E.2d 73 (W. Va. 1986).

The West Virginia Attorney General is not seeking herein to challenge the rationale of cases holding that state law remedies of *employees* who are benefit plan participants or beneficiaries are preempted from asserting state law claims, thereby decreasing the cost of funding employee benefit plans. *See, e.g., Ball v. Life Planning Services, Inc.*, 421 S.E.2d 223 (W. Va. 1992). In such cases, the West Virginia Act is not implicated because plan beneficiaries and participants were not designed to be afforded protection from insurers. Such beneficiaries and participants would have had no direct contact with the insurance company in the marketing and implementation of the insurance contract. Moreover, preemption in such instances meets with Congressional intent of encouraging employers to create benefit plans because costs are minimized when actions are limited and damages are capped.

The opposite is true, however, where an *employer* who sponsors a plan brings an action against an insurance company for fraudulent sales practices. If this type of action is preempted, or if it is held that an employer's sole remedies exist under ERISA, the cost of providing health care benefits actually increases, creating a disincentive for employers to sponsor plans. Further, the Act is rendered completely ineffective notwithstanding its clear design to protect insurance purchasers.

Under the Fourth Circuit opinion in this case, employers not only lose their state court remedies, but insurance companies are completely insulated from state laws and regulations designed to protect purchasers of insurance. The Fourth Circuit analysis completely undermines the rights of employers who have chosen to purchase insurance as part of their voluntary sponsorship of health care plans.

Also, although the issue has yet to be decided definitively, if ERISA were to apply to the exclusion of state law, it would be debatable whether an employer has an action at all and, if so,

what remedy would be appropriately crafted under ERISA. If the "delicate balance" of ERISA's remedial scheme is implicated, what remedies should be created to protect an employer in situations like this, and what amount of damages would be permitted?

West Virginia respectfully maintains that this is a matter which should be left to the States. It is a matter of negligible federal concern and of paramount importance for states like West Virginia. States should have the option to regulate the relations between insurance purchasers/employers and insurance companies, and to determine for themselves what remedies should apply.

West Virginia has a vital interest in the matters that are at issue in this case. West Virginia employers pay millions of dollars to insurance companies for insurance products which serve to fund health care plans for the benefit of West Virginia employees.

It is very important to combat unfair insurance practices and ensure the overall effectiveness of the Unfair Trade Practices Act. To that end, the private remedies provided under state statutes and common law which regulate insurance practices must be preserved, especially where they do not conflict with the fundamental goals and objectives of ERISA.

CONCLUSION

West Virginia, through its Attorney General, urges the Court to issue a writ of certiorari and decide this matter of important public concern.

Respectfully submitted,

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No. 94-972

In The Supreme Court of the United States

October Term, 1994

TRI-STATE MACHINE, INC.,

Petitioner,

v.

NATIONWIDE LIFE INSURANCE COMPANY,

Respondent.

Petition For Writ Of Certiorari To The United States Court Of Appeals For The Fourth Circuit

MOTION FOR LEAVE TO FILE BRIEF AND PROPOSED BRIEF OF *AMICUS CURIAE* HANLEY C. CLARK, INSURANCE COMMISSIONER OF THE STATE OF WEST VIRGINIA, IN SUPPORT OF GRANT OF TRI-STATE MACHINE, INC.'S PETITION FOR WRIT OF CERTIORARI

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MOTION FOR LEAVE TO FILE BRIEF *AMICUS CURIAE*

Hanley C. Clark, Insurance Commissioner of the State of West Virginia, through his counsel, moves this Honorable Court for leave to file a brief *amicus curiae* in the form of that attached hereto. Statements in support are as follows:

1. This motion for leave to file a brief *amicus curiae* is necessary under Rule 37 of the Rules of the Supreme Court because the written consent of all parties to the filing of the brief has not been granted. Petitioner Tri-State Machine, Inc. has consented to the filing of this brief. Respondent Nationwide Life Insurance Company, the other party to this case, has not refused consent, but to date has not provided oral or written consent to the filing of this brief, despite requests by the Insurance Commissioner that it do so.

2. The Insurance Commissioner's interest in this matter is great because the case has very significant ramifications for the regulation of insurance, particularly employer-sponsored health care, within the State of West Virginia.

3. The Insurance Commissioner respectfully maintains that the Court should be apprised of the West Virginia Insurance Commissioner's interest in this matter because he believes them to be highly relevant in assessing the importance, practical and legal, of this case.

4. The interests of the Insurance Commissioner are described in more depth in the attached proposed *amicus* brief, incorporated herein by reference.

For these reasons, and as more fully explained in the attached brief, the West Virginia Insurance Commissioner hereby respectfully requests leave to file the attached brief *amicus curiae*.

Respectfully submitted,

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INTEREST OF AMICUS CURIAE

This brief is filed on behalf of Hanley C. Clark, the Insurance Commissioner of the State of West Virginia, in support of the grant of the Petitioner's request for a writ of certiorari.

This case involves important questions regarding the balance of power between the federal government and the States, and the ability of West Virginia to regulate the conduct of insurance companies that sell an enormous amount of insurance to West Virginia businesses for the benefit of West Virginia workers.

SUMMARY OF ARGUMENT

The case in question raises essentially two issues which are of great consequence to the West Virginia Insurance Commissioner:

a. What is the proper scope of the Saving Clause and the Deemer Clause and how should those two clauses be read together to further the objectives of ERISA without unnecessarily impairing the time-honored and well-recognized right of the States to regulate insurance?; and

b. When is an insurance product not insurance within the meaning of the Deemer Clause?

It is time for the Supreme Court to hear and decide this case because it presents hotly contested issues which affect employers and employees in West Virginia and throughout the country. The issues are of extreme practical importance to many aspects of employer-sponsored health care and government's role in regulating the health care industry. They are issues of great social and financial importance.

ARGUMENT

Over the years, Congress and this Court have affirmed and reaffirmed the fact that the taxation and regulation of insurance should be left to the States.

From at least 1889 to 1944, Supreme Court precedent has made it clear that insurance is a matter of traditional state concern to be regulated by the States. *St. Paul Fire & Marine Ins. Co. v. Barry,* 438 U.S. 531, 539 (1978); *see Paul v. Virginia,* 75 U.S. 168, 183 (1868).

In 1944, when the Court held, in *United States v. South-Eastern Underwriters Ass'n,* 322 U.S. 533, *reh'g denied,* 323 U.S. 811 (1944), that an insurance company was subject to federal law because it was engaged in interstate commerce, the decision "provoked widespread concern that the States would no longer be able to engage in taxation and effective regulation of the insurance industry." *Barry,* 438 U.S. at 539. As a result, "Congress moved quickly, enacting the McCarran-Ferguson Act within a year of the decision in *South-Eastern Underwriters." Id.*

In passing the McCarran-Ferguson Act, 15 U.S.C. § 1101 *et seq.* (1988), "[o]bviously Congress' purpose was broadly to give support to the existing and future state systems for regulating and taxing the business of insurance." *Prudential Ins. Co. v. Benjamin,* 328 U.S. 408 (1946).

More recently, this Court described the McCarran-Ferguson Act as "restor[ing] the *supremacy* of the States in the realm of insurance regulation." *United States Dept. of the Treasury v. Fabe,* ____ U.S. ____, 113 S.Ct. 2202, 2207 (1993) (emphasis added). Finally, when Congress passed ERISA, it expressly carved out insurance regulation as a matter that must be left to the States.

Yet, judicial rulings have increasingly encroached upon the States' rights in this area. The Fourth Circuit's holding in this case finds that the West Virginia Unfair Trade Practices Act, W. Va. Code §§ 33-11-1 *et seq.* (the "Act"), is not a law regulating the business of insurance, notwithstanding that the West Virginia Act was specifically adopted in reliance on the States' ability to regulate insurance under the McCarran-Ferguson Act. *See* W. Va. Code § 33-11-1.

The Fourth Circuit's opinion and others like it expansively read ERISA's preemption provision, thereby broadening federal powers at the great expense of the States. The decision of the Fourth Circuit in this case has impaired the right and interest of West Virginia, through its Insurance Commissioner, to regulate insurance sold within West Virginia's boundaries.

A. The Relate to and Saving Clause Preemption Analysis

The Fourth Circuit opinion in this case, *Tri-State Machine, Inc. v. Nationwide Life Ins. Co.*, 33 F.3d 309 (4th Cir. 1994), allows insurance companies to successfully defend state law causes of action, including fraud claims under West Virginia's Unfair Trade Practices Act, asserted by employers who have purchased insurance for their employees.

The Fourth Circuit's opinion completely ignores the unique feature of this case in its analysis of the Act and caselaw.

The identity of Tri-State as a *purchaser* of employee benefit plan insurance is the key to the Insurance Commissioner's interest in this case. This is not a typical case where a plan participant or beneficiary is seeking duplicative remedies for improper processing of ERISA claims.

Here, the gist of Tri-State's claim is that it was defrauded in the purchase of insurance and cannot seek redress under the West Virginia Act, which was precisely crafted to protect such a purchaser. The inability of insurance purchasers to remedy wrongs under the Act obviously renders the Act completely ineffective.

The Fourth Circuit's opinion construes the "relate to" clause, 29 U.S.C. § 1144(a) (1988), *vis-a-vis* the "saving" clause, 29 U.S.C. § 1144(b)(2)(A)(1988), so as to take the regulation of a large share of insurance matters from West Virginia and place them with the federal government. The opinion will weaken West Virginia's ability to deter the unfair practices of insurance companies. It will also strip the Insurance Commissioner of the ability to ensure compliance with West Virginia's Unfair Trade Practices Act (and every other state having unfair trade practices legislation).

As such, the preemption analysis should be revisited by this Court because of its significant effect upon employers who sponsor health care plans for their workers. The Fourth Circuit's holding will have significant ramifications throughout the country as well as in West Virginia.

This Court has used the McCarran-Ferguson Act as the touchstone of saving clause analysis. *See Pilot Life Ins. Co. v. Dedeaux,* 481 U.S. 41 (1987); *Metropolitan Life Ins. Co. v. Massachusetts,* 471 U.S. 724 (1985). The Fourth Circuit's failure to recognize (i) Tri-State as a West Virginia insurance purchaser, and (ii) the interest of West Virginia in directly regulating the sale of insurance through application of its Unfair Trade Practices Act, is contrary to the dictates of the McCarran-Ferguson Act and must be reviewed.

Further, the Insurance Commissioner maintains that the question presented in this case of whether premium

manipulation "relates to" an ERISA plan in the first instance (thereby invoking preemption analysis) is an extremely important issue with great practical ramifications. It is the Insurance Commissioner's position that preemption should not arise simply because a case involves a billing dispute over the computation of premiums which are used to pay for insurance that funds an employee benefit plan.

If an employer such as Tri-State is deprived of its rights under state law, including common law contractual remedies, the employer is greatly disadvantaged and the insurance company is unnecessarily empowered in the parties' commercial relationship.

Insurance companies doing business in West Virginia are regulated by the Insurance Commissioner, but if the common law rights of West Virginia's employers are taken away, much of the State's ability to "regulate" insurance companies is lost.

B. The Deemer Clause Analysis

The Fourth Circuit majority opinion also broadens the scope of a self-funded plan to include an insured plan when the insured plan in question is categorized as self-funded "for the most part." *Tri-State Machine, Inc. v. Nationwide Life Ins. Co.*, 33 F.3d 309, 315 (4th Cir. 1994).[1] The Fourth

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[1]The Fourth Circuit referenced its opinion in *Thompson v. Talquin Building Products Co.*, 928 F.2d 649, 653 (4th Cir. 1991), as support for this finding. However, *Thompson* involved a dispute arising out of a self-funded plan that had purchased stop-loss insurance, and there the terms of the stop-loss policy and its funding had nothing to do with the dispute. In the instant case, the plan was *funded* by the purchase of insurance and the dispute arises out of alleged unfair practices in the computation of premiums charged by an insurance company for the insurance in question—a matter of deep concern to those charged with the duty of regulating insurance practices.

Circuit broadens the scope of preemption (correspondingly, narrowing the States' ability to regulate insurance) by ruling that insurance products which are partially self-funded invoke application of the Deemer Clause. 29 U.S.C. § 1144(b)(2)(B)(1988).

This holding is nonsensical because the Deemer Clause protects employee benefit plans, not insurance policies or insurance companies, from compliance with state insurance law. *See Tri-State Machine,* 33 F.3d at 318-19 (Luttig, J., dissenting). The Deemer Clause is inappropriately invoked because suit was not instituted against the employee benefit plan.

Further, an insurance product is either insurance to some extent, or it is not (in which case it is not insurance). But the Fourth Circuit adopts a new idea that something which is self insurance "for the most part" invokes the Deemer Clause. This is akin to being half pregnant.

Insurance, plain and simple, exists when risk of loss is transferred to an insurance company. When a product labeled "insurance" transfers no risk because, through some mechanism, *all* benefits paid are passed through to the purchaser, it is not insurance; it is a self-funded plan, and the "insurance company" is then acting as a third party administrator, not an insurer.

Many employers in West Virginia, like employers throughout the country, fund employee benefit plans through the purchase of insurance. These plans may contain stop-loss components, such as (i) the implementation of high deductibles, or (ii) premiums based dollar-for-dollar upon benefits paid up to some amount for any number of categories (*e.g.,* per employee, per prescription drug, per month). But to the extent that benefit plans established

through the purchase of insurance transfer risk to an insurance company, they are insurance.

To hold that an insurance product is not insurance because it is partially "self-funded" enormously and unnecessarily complicates the Deemer Clause analysis. It is very important that the Supreme Court address this matter and draw a bright line; otherwise, the ability of States like West Virginia to effectively regulate the business of insurance falls into question.

CONCLUSION

This case is of extreme importance because it impairs the ability of States to regulate the practices of insurers selling employee benefit insurance products. Congress was clear with its passage of the McCarran-Ferguson Act that States should have the right to regulate insurance. However, with decisions such as the Fourth Circuit's in this case, the courts are unnecessarily stripping the States of their ability to regulate the business of insurance.

The case is also important because it expands the scope of the Deemer Clause to employee benefit plans that are not completely self-funded, thereby further restricting the application of state insurance law.

Finally, a decision based on facts such as presented in this case should not be made in a legal vacuum. The States each have an organization in place for the regulation of insurance and the protection of policyholders. This is not true of the federal government. Consequently, a ruling that state insurance regulation is preempted is also a ruling that purchasers of insurance effectively have no legal protection.

It is extremely important to the Insurance Commissioner that the recognized right of the States to regulate and tax insurance companies is not taken away or unnecessarily impaired. As such, the Insurance Commissioner of the State of West Virginia requests that this Court issue a Writ of Certiorari to the Fourth Circuit in this case.

Respectfully submitted,

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No. 94-972

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v.

NATIONWIDE LIFE INSURANCE COMPANY,

Respondent.

Petition For Writ Of Certiorari
To The United States Court Of Appeals
For The Fourth Circuit

MOTION FOR LEAVE TO FILE BRIEF OF AMICUS CURIAE AND PROPOSED BRIEF OF NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS AS AMICUS CURIAE IN SUPPORT OF THE PETITION FOR WRIT OF CERTIORARI

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MOTION FOR LEAVE TO FILE A BRIEF OF AMICUS CURIAE

The National Association of Insurance Commissioners (NAIC), through its counsel, respectfully moves this Honorable Court for leave to file a brief of *amicus curiae* in the form attached hereto in support of Petitioner Tri-State Machine, Inc.'s Petition for Writ of Certiorari to the United States Court of Appeals for the Fourth Circuit now pending in this Honorable Court. In support for this motion, the NAIC states the following:

1. This motion for leave to file a brief of *amicus curiae* is required by Rule 37.2 of the Rules of the Supreme Court because the written consent of all parties to the filing of the brief of *amicus curiae* has not been granted. Petitioner Tri-State Machine, Inc. has consented to the filing of this brief. Respondent Nationwide Life Insurance Company has been contacted by the undersigned counsel for the NAIC and its consent has been requested; however, Respondent has refused to consent to the filing of this brief.

2. The objective of the NAIC is to serve the public interest by assisting its members, the chief insurance supervisory officials of the fifty States, the District of Columbia, the territories and the insular possessions of the United States, in promoting the fair, just and equitable treatment of insurance consumers and claimants, the reliability of the insurance institution as to solvency, financial solidity and guaranty against loss, and the maintenance and improvement of State regulation of insurance.

Accordingly, the interest of the members of the NAIC in this matter is great because of the significant ramifications for the regulation of the business of insurance in all jurisdictions and the potential effects that this decision may have on insurance consumers whose interests the members of the NAIC, through this motion, seek to protect.

3. The NAIC respectfully urges that the Court should be apprised of the interest of the fifty-five members of the NAIC in this matter because the West Virginia Unfair Trade Practices Act, which is a primary issue in the case, is based upon the NAIC Model Unfair Trade Practices Act. The Model also forms the basis for similar statutes in a majority of the States. The decision by this Court will impinge insurance regulation and insurance consumer protection in all jurisdictions.

4. The interests of the NAIC are described in detail in the attached proposed brief of *amicus curiae,* incorporated herein by reference.

For these reasons and as more fully described in the attached proposed brief, the National Association of Insurance Commissioners, through its counsel, respectfully requests leave to file the attached brief of *amicus curiae.*

Respectfully submitted,

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No. 94-972

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IDENTITY OF AMICUS CURIAE

The National Association of Insurance Commissioners (NAIC) is a non-profit, unincorporated association whose membership consists of the commissioners, directors, superintendents, or other officials who are charged by law with the principal responsibility of supervising the business of insurance in 50 states, the District of Columbia, the territories and the insular possessions of the United States.

The goal of the NAIC, set out in its Constitution, is to serve the public by assisting these insurance supervisory officials in achieving these fundamental objectives:

1. Promotion of the public interest through the regulation of insurance and the fair, just and equitable treatment of insurance consumers and claimants;

2. Reliability of the insurance institution as to solvency, financial solidity and guaranty against loss; and

3. Maintenance and improvement of State regulation of insurance in a responsive and efficient manner.

NAIC Constitution, Article II. Amended 1993 Proc. Second Quarter, 19.

One of the most important services the NAIC provides for its members is the development and drafting of model statutes and regulations. These models are intended to serve only as guideposts for members to assist them in presenting appropriate insurance legislation for enactment in the various state legislatures and in adopting appropriate regulations for more efficient and effective regulation of insurance in the states.

INTEREST OF THE AMICUS CURIAE

The NAIC is interested in filing this brief in furtherance of its goal as articulated above. Furthermore, the NAIC Executive Committee, which is comprised of seventeen state insurance officials from all regions of the United States, voted to file a brief of *amicus curiae* in this case on behalf of all fifty-five members of the NAIC. The interest of the NAIC in filing this brief is based on the premise that the U.S. Congress intended, by enacting the McCarran-Ferguson Act, 15 U.S.C. § 1011 *et seq.*, that the States shall have the exclusive authority to regulate the business of insurance. The NAIC was a principal participant in the drafting and debate of the McCarran-Ferguson Act. Its members historically have supported state regulation of insurance against expansive preemption by federal laws because " . . . the continued regulation and taxation by the several States of the business of insurance is in the public interest, and . . . silence on the part of the Congress shall not be construed to impose any barrier to the regulation or taxation of such business by the several States." McCarran-Ferguson Act, 15 U.S.C. § 1011 *et seq.* After the enactment of the McCarran-Ferguson Act in 1945 (Public Law 15, 79th Congress), the NAIC initiated efforts to develop state legislation regulating insurer trade practices. The NAIC considered it extremely important to establish unequivocally the intent of state legislatures to occupy the field of state regulation of insurer trade practices. 1946 NAIC Proc. 145, 148.

In 1947, the NAIC adopted its Model Unfair Trade Practices Act. In the intervening years, the NAIC has amended this Model Act to strengthen regulation of

insurer trade practices; however, its primary purpose has remained substantially unchanged:

"The purpose of this Act is to regulate trade practices in the business of insurance in accordance with the intent of Congress as expressed in the Act of Congress of March 9, 1945, (Public Law 15, 79th Congress), by defining, or providing for the determination of, all such practices in this state that constitute unfair methods of competition or unfair or deceptive acts or practices and by prohibiting the trade practices so defined or determined . . . "

1993 NAIC Proc. I 246-254 (amended and reprinted).

Almost all the various States have adopted the NAIC Model Unfair Trade Practices Act or legislation that is considered similar to the Model. The West Virginia Unfair Trade Practices Act, W. Va. Code § 33-11-1 *et seq.*, although different in some respects, is based on the NAIC Model.

Consistent with its objectives and its historical positions, the NAIC has an interest in minimized federal involvement in state regulation of the business of insurance. The decision of the Fourth Circuit in this case has a significant impact on the capacity and ability of the members of the NAIC to regulate the business of insurance in the various States. Several areas of traditional state regulation are impinged by the decision, including regulation of the sale of insurance products, regulation of the relationship between an insurer and an insured, and state law jurisdiction over insurer trade practices. The decision expands preemption by the Employee Retirement Income Security Act (ERISA) of 1974, 29 U.S.C. § 1001, *et seq.*, to

encompass insurer practices without regard for applicable state laws designed to protect insurance consumers from unfair and fraudulent practices.

The case should be heard by the Supreme Court of the United States because of its significant impact on state regulation of the business of insurance and state insurance laws in the various States. The case presents questions of important public concern. States have an interest in regulating the activities of insurers. Each State has a specific scheme to regulate the business of insurance within its jurisdiction. These state schemes differ according to the needs of the insurance consumers of the states. However, consistent among these state schemes is the regulation of insurer trade practices. The States have occupied the field of regulation of insurer trade practices. The decision of the Fourth Circuit would exclude the States from a major portion of that field – the relationship between an insurer and an insured – leaving aggrieved insurance consumers without appropriate state remedies.

SUMMARY OF ARGUMENT

The NAIC considers that there are three issues raised by the decision of the Fourth Circuit that are very important to its members and its objectives:

1. Is the West Virginia Unfair Trade Practices Act an insurance law within the meaning of "the business of insurance" in the McCarran-Ferguson Act?

2. Does proper interpretation of the "Relate To" Clause of the preemption provision of ERISA and the

"Saving" Clause of ERISA exempt state laws regulating insurer trade practices from the preemption clause of ERISA?

3. Does the "Deemer" Clause of ERISA apply to an employee benefit plan funded by an insurance policy, which policy contained a stop-loss provision, causing the plan to be self-funded in part, thus saving from preemption a state law regulating insurer trade practices?

These issues are answered in the affirmative by evaluating the various applicable provisions of the McCarran-Ferguson Act and ERISA and by analyzing the bodies of case law which have arisen as a result of enactment of both federal laws.

The term "the business of insurance" contained in the McCarran-Ferguson Act includes the relationship between an insurer and an insured. The West Virginia Unfair Trade Practices Act, like the NAIC Model Unfair Trade Practices Act, is a law regulating the relationship between an insurer and an insured. That relationship includes the gathering, compiling, and analyzing of claims data by the insurer for the purpose of determining premiums which shall be charged to the insured pursuant to the insurance policy, as in this case.

The "Relate To" clause of the preemption provision of ERISA does not encompass elements of the underlying relationship created through the issuance and delivery of an insurance policy between an insurer and an insured which funds an employee benefit plan.

Finally, the "Deemer" clause excludes self-funded plans from the "Saving" clause of ERISA. The insurance

policy at issue in this case is a policy which funds an employee benefit plan and which has stop-loss provisions capping premium obligations of the insured. The presence of these stop-loss provisions does not render the plan self-funded.

ARGUMENT

I. BACKGROUND

Tri-State Machine, Inc., Petitioner, contracted with Nationwide Life Insurance Company to provide a combination life, health and disability insurance policy to fund Petitioner's employee benefit plan. Premiums were calculated according to a funding agreement. Premium obligations of Petitioner generally were based on claims of Petitioner's employees; however, Petitioner's premium obligations were limited to an annual maximum amount, a provision that might be found in a stop-loss policy. After a number of years in this relationship, Nationwide was required to report to Petitioner claims information and to recalculate Petitioner's premium obligations. In so doing, Nationwide is alleged to have improperly manipulated claims information and to have violated the funding agreement, resulting in a premium increase billed to Petitioner and a recoupment of funds for Nationwide.

Petitioner initially brought suit in a West Virginia state court alleging breach of contract, breach of implied covenant of good faith and fair dealing, statutory "bad faith," and violation of various West Virginia insurance laws. The suit was removed to the United States District Court for the Northern District of West Virginia based on

diversity and on Nationwide's response to the suit which alleged that all the claims of Petitioner were preempted by ERISA.

After some procedural issues were resolved, the trial court issued a final order finding that Petitioner's state law causes of action were preempted by ERISA. The Fourth Circuit affirmed the trial court finding that Petitioner's claims "related to" an ERISA plan, the state insurance laws alleged to be applicable were not "saved" from preemption, the Petitioner's employee benefit plan was a self-funded plan to which the "deemer" clause of ERISA applied, and the West Virginia Unfair Trade Practices Act was not an insurance law as contemplated by the McCarran-Ferguson Act and thus its application in this case was preempted by ERISA. *Tri-State Machine, Inc. v. Nationwide Life Ins. Co.*, 33 F.3d 309 (4th Cir. 1994).

Petitioner has timely filed its Petition for Certiorari to the United States Court of Appeals for the Fourth Circuit in the Supreme Court of the United States.

II. MCCARRAN-FERGUSON ACT AND ERISA PREEMPTION

Although it is clear that Congress may invoke federal supremacy and supplant state statutes and common law with federal law, Congress has also clearly reserved the regulation of the business of insurance to the states. ERISA's preemption provisions are expansive, but they cannot and do not provide for unlimited preemption of state laws in matters relating to the business of insurance.

In 1945, primarily in response to this Court's decision in *United States v. South-Eastern Underwriters Ass'n* (322 U.S. 533, *reh. denied,* 323 U.S. 811 (1944)), the Congress passed the McCarran-Ferguson Act, declaring that "the business of insurance, and every person engaged therein, shall be subject to the several States which relate to the regulation or taxation of such business." 15 U.S.C. § 1012(a).

The Congress went on in the Act to emphasize the important public purpose for this reservation to the States stating in part that " . . . the continued regulation and taxation by the several States of the business of insurance is in the public interest, and . . . silence on the part of the Congress shall not be construed to impose any barrier to the regulation or taxation of such business by the several States." 15 U.S.C. § 1011.

Furthermore, Congress imposed limitations on itself in the Act declaring that "no Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance." 15 U.S.C. § 1012(b).

The McCarran-Ferguson Act is unique among federal laws in its delegation of exclusive authority to the States to regulate the business of insurance.[1] The Act is not unique, however, in that the lack of specificity contained

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[1] Jonathan R. Macey, Geoffrey P. Miller, *Costly Policies: State Regulation and Antitrust Exemption in Insurance Markets,* AEI Studies in Regulation and Federalism, 1993, p. 2.

therein has given rise to a very large body of case law developed over the years since its enactment which attempts to define what the Congress meant in making such sweeping statements about "the business of insurance."

Case law has defined what is meant by "the business of insurance" as contemplated by the McCarran-Ferguson Act. Antitrust cases have identified several elements which are common to "the business of insurance."[2]

- Risk spreading: If an activity has the effect of transferring or spreading a policyholder's, or an insured's risk, then the activity is considered "the business of insurance" subject to regulation by the States. *Union Labor Life Insurance Co. v. Pireno,* 458 U.S. 119, 129 (1982).

- Relationship to an insurance policy: If an activity is an "integral part of the policy relationship between the insurer and the insured," then it is "the business of insurance" subject to regulation by the States. *Id.* at 126.

- Intra-industry activity. If an activity is "limited to entities within the insurance industry," it is deemed "the business of insurance." *Group Life & Health Insurance Co. v. Royal Drug Co.,* 440 U.S. 205, 224 (1979). This criteria is premised upon the legislative history of

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[2] In a recent case, not an anti-trust case, this Court referred to the McCarran-Ferguson Act as "restor[ing] the supremacy of the States in the realm of insurance regulation." *United States Dept. of the Treasury v. Fabe,* ___ U.S. ___, 113 S.Ct. 2202, 2207 (1993).

the McCarran-Ferguson Act and is primarily responsible for the narrowing of case law in determinations of "the business of insurance."

The application of these elements to a fact situation will not always result in consistent or predictable results. Additionally, the application of ERISA to the fact situation further complicates the analysis.

The preemption provision of ERISA reads as follows: "Except as provided in subsection (b) of this section, the provisions of this title and title IV shall supersede any and all State laws insofar as they may not or hereafter relate to any employee benefit plan described in section 4(a) and not exempt under section 4(b)." 29 U.S.C. § 1144(a). ERISA was enacted to encourage employer-sponsored employee benefit plans by defining and limiting the claims and remedies that are exclusively available to plan beneficiaries and participants. The preemption provision cited above was designed to minimize the burden of compliance by plans and their employer-sponsors with conflicting state laws.

The "relate to" clause of the preemption provision of ERISA should not be read to encompass traditional areas of state regulation. ERISA prescribes specific remedies which are exclusively available to plan beneficiaries and participants. In some cases, employer-sponsors were left without remedies because the ruling court held that the claims were preempted, but there was no remedy prescribed by ERISA. *See, e.g., Farlow v. Union Cent. Life Ins. Co.*, 874 F.2d 791, 794 (11th Cir. 1989), and *Consolidated Beef Indus. v. New York Life Ins. Co.*, 949 F.2d 960, 964 (8th Cir. 1991) *cert. denied*, ___ U.S. ___, 112 S.Ct. 1670 (1992).

The more rational approach, and the approach which is consistent with the intent of Congress in the McCarran-Ferguson Act, is the approach which limits the preemptive effect of the "relate to" clause to benefits administration and processing issues. *See, e.g., Airparts Co., Inc. v. Custom Benefit Services of Austin, Inc.*, 28 F.3d 1062 (10th Cir. 1994), and *Perry v. P*I*E Nationwide, Inc.*, 872 F.2d 157 (6th Cir. 1989), *cert. denied*, 493 U.S. 1093 (1990). These courts and others have essentially found that a law's indirect effect on a plan does not necessitate its preemption because of the "relate to" clause. In other words, there must be more than a tenuous or remote relationship between the law in question and the plan in order for the law to be preempted. Otherwise, the words of Congress in enacting the McCarran-Ferguson Act are rendered meaningless.

This Court has denied *certiorari* in these lines of cases, leaving doubt as to the proper analysis to be applied by courts in adjudging controversies. This case presents the Court with the opportunity to resolve the confusion.

III. ERISA "SAVING" CLAUSE

The ERISA "saving" clause reads as follows: "Neither an employee benefit plan described in section 4(a), which is not exempt under section 4(b) (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be

engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies." 29 U.S.C. § 1144(b)(2)(A).

This Court has previously reviewed the ERISA "saving" clause and has concluded that a common sense understanding of the term "regulate insurance" should first be applied and then the McCarran-Ferguson Act test should be applied to determine whether the law in question regulates the business of insurance. *See, e.g., Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, and *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 743 (1985). If one scrutinizes the decision of this Court in *Pilot Life*, one concludes that the McCarran-Ferguson Act test alone does not address the application of preemption to litigants which are not specifically listed in ERISA. It is not rational to conclude that Congress intended to preempt all remedies available under state law to a non-fiduciary employer-sponsor of a plan, where no remedies are cited under the exclusive remedy provisions of ERISA.

Furthermore, this Court has held that "the saving clause retains the independent effect of protecting state insurance regulation of insurance contracts purchased by employee benefits plans." *FMC Corp. v. Holliday*, 498 U.S. 52, 64 (1990). Application of that holding to the instant case would result in the correct approach, which would permit Petitioner to pursue its state law remedies and would halt the expansion of ERISA preemption into areas not contemplated in ERISA.

IV. ERISA "DEEMER" CLAUSE

The ERISA "deemer" clause limits the effect of the "saving" clause stating that " . . . no employee benefit plan shall be deemed to be an insurance company or other insurer . . . or . . . engaged in the business of insurance . . . for purposes of any law of any state purporting to regulate insurance companies [or] insurance contracts." 29 U.S.C. § 1144(b)(2)(B).

This Court interpreted the "deemer" clause to exempt from state laws that regulate insurance ERISA plans. However, this Court also found that state laws that "directly regulate insurance are 'saved' but do not reach self-funded employee benefits plans because the plans may not be deemed to be insurance companies . . . " *FMC Corp. v. Holliday,* 498 U.S. 52, 61 (1990).

The question here relates to the characteristics of a self-funded plan. A self-funded plan, by definition, is not an insured plan. The difficulty arises when a plan is an insured plan, but the employer-sponsor retains some risk itself. Notwithstanding the holding of this Court in *FMC Corp.*, the "deemer" clause has been applied to plans that were insured, but where the employer-sponsor retained some of the risk. The Fourth Circuit applied the "deemer" clause to the plan at issue here finding that it was "self-funded for the most part." *Tri-State Machine,* 33 F.3d at 315. The Sixth Circuit, by contrast, has held that the existence of any insurance on its face means a plan is not self-funded. *See, e.g., Northern Group Services, Inc. v. Auto*

Owners Ins. Co., 833 F.2d 85 (6th Cir. 1987), *cert. denied*, 86 U.S. 1017 (1988).[3]

This case provides an opportunity for this Court to clarify its holding in *FMC Corp.* and emphasize that where any risk under a plan is insured, state law may be invoked to remedy claims which arise from the insurance policy, and that the "deemer" clause is not applicable to insurance companies in the sale of insurance policies.

CONCLUSION

The implications raised by the issues in this case are far-reaching in several respects.

First, the diverse decisions of many courts in attempting to rationalize the cited ERISA provisions with the supremacy of the States to regulate the business of insurance have resulted in conflicting, sometimes contradictory and confusing results. There is no guidance to resolutions of controversies at the trial court or the intermediate appellate court levels. Resolution of these issues by this Court will provide needed guidance for courts as well as prospective litigants.

Second, ERISA was intended to encourage and facilitate creation of employer-sponsored benefit plans for employees. The Fourth Circuit's interpretation of ERISA has the opposite result. Employers are discouraged from

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[3] The holding in *Northern Group* was limited; however, the situation differed from the situation in the instant case, one in which the employer-sponsor purchased insurance to fund the employee benefit plan. See *Lincoln Mut. Casualty Co. v. Lectron Products, Inc. Employee Health Plan*, 970 F.2d 106 (6th Cir. 1992).

creating such plans because when insurance policies are purchased to fund all or part of the plan, the employers are not protected by ERISA from unfair trade practices by insurance companies. ERISA was not intended to and does not provide such protections and, indeed, there is no accountability for insurers engaging in such practices.

Finally, there is broad-based, diverse support in the United States now for health care reform and, more importantly for this case, for employer-sponsored and provided health insurance. The trend indicated by the Fourth Circuit's decision expands inappropriately the force of the ERISA preemption so broadly as to apply to transactions unintended by Congress. Continuation of this trend will serve to undermine the efforts to secure health care reform through employer-sponsored health benefits.

The NAIC, as *amicus curiae*, respectfully requests the Court to grant the writ of *certiorari* in this case and to reaffirm that regulation of the business of insurance is reserved exclusively to the States and that ERISA preemption does not prevent the States from providing the consumer protection contemplated by unfair trade practices laws applicable to insurers.

Respectfully submitted,

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APPENDIX

CONSTITUTION

ARTICLE I. NAME.

This organization shall be known as the National Association of Insurance Commissioners (NAIC).

ARTICLE II. OBJECTIVE.

The objective of this body is to serve the public by assisting the several State insurance supervisory officials, individually and collectively, in achieving the following fundamental insurance regulatory objectives:

(1) Promotion of the public interest through the regulation of insurance and the fair, just and equitable treatment of insurance consumers and claimants;

(2) Reliability of the insurance institution as to solvency, financial solidity and guaranty against loss; and

(3) Maintenance and improvement of State regulation of insurance in a responsive and efficient manner.

ARTICLE III. MEMBERSHIP.

The membership of the NAIC shall consist of the Commissioners, Directors, Superintendents, or other officials who by law are charged with the principal responsibility of supervising the business of insurance within each State, territory, or insular possession of the United States. Members only shall be eligible to hold office in and serve on Committees and Subcommittees of the NAIC. However, a member may be represented on a Committee or

Subcommittee by the member's duly authorized representative as defined in ARTICLE VII. Each State, territory or insular possession shall be limited to one vote. Any insurance supervisory official of a foreign government or any subdivision thereof, which has been diplomatically recognized by the United States government, may attend and participate in all meetings of this Congress but shall not have the power to vote.

Members failing to pay all NAIC assessments on a timely basis, as prescribed by the Bylaws, shall be placed in an inactive status. Members in an inactive status shall be denied membership on NAIC committees and task forces, access to mailings and services of the NAIC Support and Services Office, as well as access to zone examination processes and other benefits of membership in the NAIC.

Receipt of full payment from the inactive member of all current and past due assessments shall serve to immediately remove them from the inactive status.

The Executive Committee is empowered to reinstate, in part or in whole, an inactive member's participation on the committees and task forces, access to mailings and services of the NAIC Support and Services Office, as well as access to zone examination processes, and other benefits of membership in the NAIC upon good cause shown as determined by the Executive Committee.

ARTICLE IV. ZONES.

To accomplish the purposes of the NAIC in a timely and efficient manner, the United States, its territories and insular possessions shall be divided into four Zones. Each

Zone shall consist of a group of at least eight States, located in the same geographical area, with each State being contiguous to at least one other State in the group so far as practicable, plus any territory or insular possession that may be deemed expedient, all as determined by majority of the Executive Committee. Members of each Zone shall annually elect a Chairman, a Vice Chairman and a Secretary from among themselves prior to or during the Winter Meeting of the NAIC. The Chairman, Vice Chairman and Secretary of each Zone shall be members of the Executive Committee with terms of office corresponding to that of the officers. Each Zone shall perform such functions as are designated by the Executive Committee of the NAIC or by the members of the NAIC as a whole or by the members of the Zone. Each Zone may hold Zone Meetings for such purposes as may be deemed appropriate by members of the Zone. Zone Meetings may be held at the discretion of the Zones as long as the meeting is not held within thirty (30) days of a National Meeting or within twenty-one (21) days of a previously scheduled Zone Meeting.

ARTICLE V. MEETINGS.

The NAIC shall hold at least four (4) National Meetings each calendar year at such time and place as the Executive Committee may designate; provided that each Zone shall be the site of one National Meeting every two years. Special plenary sessions may be called by any five (5) members of the Executive Committee by giving all members notice of such meeting at least ten (10) days prior thereto, or by any twenty (20) members of the NAIC upon thirty (30) days notice to all members. Actions at

any special plenary sessions shall be limited to the object stated in the notice therefor. At any meeting of the NAIC, one or more of the sessions may be Executive Sessions. Any member may attend and participate in any meeting of the NAIC or any meeting of a Committee or Task Force whether or not such member has the right to vote. All National Meetings shall provide for a Plenary Session of the NAIC as a whole in order to consider and take action upon the matters submitted to the NAIC.

ARTICLE VI. QUORUM.

A quorum for the transaction of business shall consist of a majority of the members.

ARTICLE VII. VOTING.

Each member of the NAIC shall have the power to vote and otherwise participate in the affairs of the NAIC provided, however, no State, territory or insular possession shall have more than one vote. This power may be exercised through a duly authorized representative who shall be a person officially connected with the member's department and is wholly or principally employed by said department. Any delegation of power to vote or participate in the affairs of the Plenary Session, Executive Committee or Standing Committee of the NAIC during the regular meetings of the NAIC must be in writing.

ARTICLE VIII. OFFICERS.

The officers of the NAIC shall be a President, a Vice President who shall serve as Chairman of the Executive

Committee, and a Recording Secretary. The officers shall be elected by secret ballot at the last National Meeting of the calendar year and shall take office at the close of such meeting. They shall hold office until the election and qualification of their successors. No member may hold the office of President or Vice President – Chairman of the Executive Committee – for more than two consecutive years.

ARTICLE IX. EXECUTIVE COMMITTEE.

(1) Structure and Composition.

(a) There shall be an Executive Committee consisting of the officers of the NAIC; the most immediate past President who shall be Vice Chairman of the Executive Committee; the twelve (12) members of the zones as provided in ARTICLE IV; and all other past presidents who have continuously remained members of the NAIC since completing their terms in the office of NAIC president.

(b) Vacancies in the office of President, Vice President or Recording Secretary may be filled by the Executive Committee for the remaining period until the next Plenary Session of the NAIC. In the event of such vacancy, the Chairman of the Executive Committee, or in case of his inability to act from any cause, the Vice Chairman, or if he is unable, the President, may call a meeting of or conduct a mail ballot among the members of the Executive Committee to fill such vacancy until the next Plenary Session of

the NAIC. If the vacancy is that of Chairman of the Zone, Vice Chairman of the Zone or Secretary of the Zone, the Chairman of the Zone, or in his absence, the Vice Chairman, shall immediately call a meeting of or conduct a mail ballot among the members of the Zone to fill such vacancy. In the event the immediate past President is unable, for any reason, to act as Vice Chairman of the Executive Committee, the membership of the Executive Committee shall elect one of their number to act as Vice Chairman, but no vacancy on the Executive Committee shall result from such inability of the immediate past President or from such election of a member to act as Vice Chairman.

(2) General Authority and Responsibility.

The Executive Committee shall have the authority and responsibility to:

(a) make recommendations to achieve the goals of the NAIC based upon either its own initiative or the recommendations of the Standing Committee or Subcommittees reporting to it, for consideration and action by the members at any NAIC Plenary Session;

(b) manage the affairs of the NAIC in a manner consistent with the Constitution and Bylaws;

(c) create and terminate one or more Task Forces reporting to it to the extent needed and appropriate;

(d) establish and allocate, from time to time, functions and responsibilities to be performed by each Zone;

(e) establish, to the extent needed and appropriate, and oversee in accordance with the Bylaws, a Support and Services Office to assist the NAIC and the individual members in achieving the goals of the NAIC;

(f) submit to the NAIC at each National Meeting, during which a Plenary Session is held, its report and recommendations concerning the reports of the Standing Committees. All Standing Committee reports shall be included as part of the Executive Committee report;

(g) plan, implement and coordinate communications and activities with other state, federal and local government organizations in order to advance the goals of the NAIC and promote understanding of state insurance regulation.

ARTICLE X. BYLAWS.

The Bylaws of the NAIC may prescribe the powers and duties of the several officers and Committees of the NAIC and such rules as may be necessary for the work of the NAIC provided they are in conformity with this Constitution.

ARTICLE XI. AMENDMENTS.

This Constitution may be altered or amended at any Plenary Session of the NAIC by an affirmative vote of

two-thirds of the members qualified to vote, or their authorized representatives, provided that previous notice of the proposed amendment has been mailed to all members by direction of the Executive Committee at least thirty (30) days prior to the meeting.

Adopted 1981 Proc. I p. 41
Amended 1981 Proc. II p. 27
Amended 1984 Proc. II p. 14
Amended 1985 Proc. I p. 32
Amended 1989 Proc. II p. 11
Amended 1993 Proc. Second Quarter p. 6
Amended 1994 Proc. Second Quarter

SUPREME COURT, U.S.
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No. 94-972

In The

Supreme Court of the United States

October Term, 1994

TRI-STATE MACHINE, INC.,

Petitioner,

vs.

NATIONWIDE LIFE INSURANCE COMPANY,

Respondent.

On Petition For Writ Of Certiorari
To The United States Court Of Appeals
For The Fourth Circuit

RESPONSE TO MOTION FOR LEAVE TO FILE BRIEF OF AMICUS CURIAE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

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Now comes Respondent, Nationwide Life Insurance Company, pursuant to Rule 21.4 of the Supreme Court Rules, and herein files its response to the National Association of Insurance Commissioners' ("NAIC") Motion for Leave to File a Brief of Amicus Curiae in Support of Petition for Writ of Certiorari to the United States Court of Appeals for the Fourth Circuit. For the reasons that follow, Respondent submits that the Court should deny NAIC's Motion for Leave.

At issue in this case is whether ERISA preemption should apply to the claims of the plan sponsor of an ERISA employee welfare benefit plan who seeks relief against a plan fiduciary of that plan. Specifically, Petitioner Tri-State Machine Company, the plan sponsor, seeks state law remedies against Respondent, as plan fiduciary, for misadministration of plan benefits under the subject employee welfare benefit plan, breach of duty with regard to administration of plan benefits, negligence, breach of contract and bad faith. All claims alleged by the plan sponsor directly implicate the manner in which the plan fiduciary administered claims.

Based upon the complaint filed by Petitioner in the trial court, The United States District Court for the Northern District of West Virginia determined that Petitioner's claims were preempted by ERISA and not saved therefrom. The Fourth Circuit Court of Appeals agreed with that determination. *Tri-State Machine v. Nationwide Life Insurance Company*, 33 F.3d 309 (4th Cir. 1994). Both courts below consequently determined that Petitioner was not entitled to the state law remedies it seeks against Respondent.

Amicus, NAIC, seeks leave to file its brief in support of Tri-State's Petition for Writ of Certiorari. The argument made by the NAIC provides a cursory analysis of the ERISA preemption provisions and West Virginia's Unfair Trade Practices Act. Like the brief of the other amici curiae, the Attorney General and the Insurance Commissioner of the State of West Virginia, the brief of NAIC does not bring to the attention of the Court relevant matter that has not already been brought to its attention by the parties. NAIC's amicus brief, like the previous amicus briefs in support of Tri-State's Petition, do not in any way raise issues which should be considered by the Court in this case.

The NAIC brief does nothing to shed light on the issues central to this case. NAIC does not discuss the sweeping scope of ERISA preemption as defined by Congress. Without addressing this Court's numerous decisions elaborating on the broad scope of ERISA preemption, amicus instead discusses its perception of the effect of the McCarran-Ferguson Act on ERISA preemption, ignoring the fact that the McCarran-Ferguson Act was passed thirty years prior to the enactment of ERISA. In this regard, amicus would have the court ignore the mandate of federal preemption of ERISA claims, defined both by Congress and this Court, in favor of providing state law remedies to a party where that party's claims are clearly governed by ERISA.

NAIC, like the other amici who have filed briefs in support of the Petition for Writ of Certiorari, glosses over the sound and consistent application of the ERISA preemption analysis which this Court has applied in numerous cases for more than a decade. (See e.g. *Shaw v.*

Delta Airlines, Inc., 463 U.S. 85 (1983); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987); *FMC Corp. v. Holliday*, 498 U.S. 52 (1990)). Amicus brings no relevant matter which has not already been brought to the court's attention by the parties with regard to the preemption analysis.

Rule 37 of the Supreme Court Rules provides that an amicus brief which does not serve the purpose of bringing relevant matter to the attention of the Court that has not already been brought to its attention is not favored. Moreover, Rule 37 provides that a motion for leave to file a brief amicus curiae is not favored when consent has been refused. Respondent refused to give consent to NAIC and the Commissioner of Insurance of the State of West Virginia for the filing of their respective amicus briefs. Consent was refused to NAIC on the basis that the issues germane to a decision on the Petition for Writ of Certiorari have already been brought to the Court's attention.

Because the issues which Petitioner has brought before the Court have been addressed without the assistance of amicus, because the amicus brief does not serve the purpose of bringing relevant matter to the attention of the Court that has not already been brought to the Court's attention, and because Respondent has refused consent to the filing of the amicus brief, Respondent

respectfully submits that the Court should deny NAIC's Motion for Leave to File Brief of Amicus Curiae.

Respectfully submitted,

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